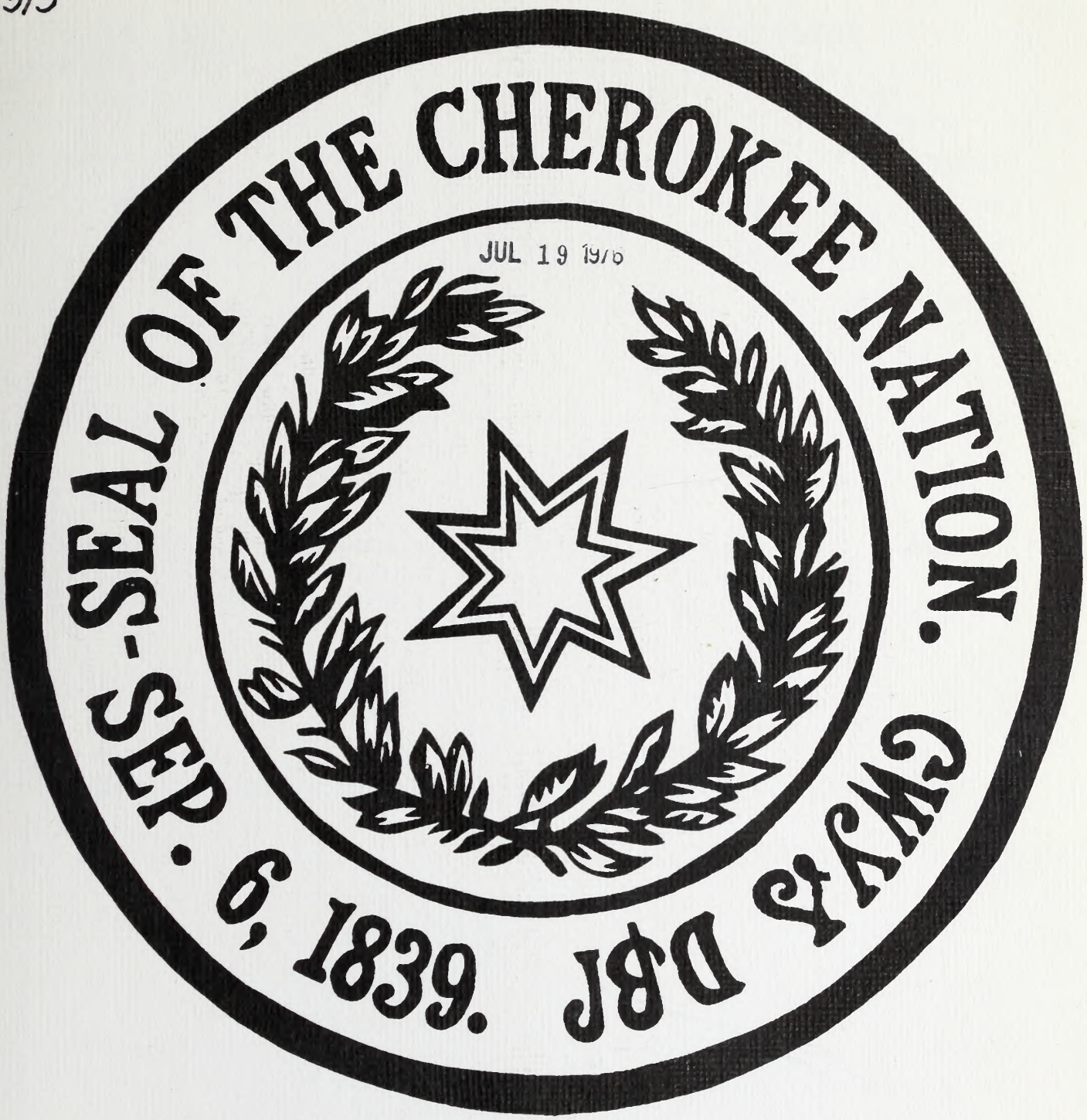

CHEROKEE

SERVICE UNIT

PROGRAM PLAN FY-76-77

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CHEROKEE SERVICE UNIT - PROGRAM PLAN

FISCAL YEAR 1976 - 1977

Prepared By:

Program Plan Committee
Cherokee Indian Hospital

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE
CHEROKEE, NORTH CAROLINA

Cherokee Service Unit - Program Plan
Eastern Band of Cherokee Indians
For Fiscal Year 1976 - 1977

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Table of Contents

(cont.)

LIST OF TABLES

LIST OF MAPS

LIST OF GRAPHS

Introduction

The objective of the Cherokee Program Plan is to raise the health status of every enrolled member of the Eastern Band of Cherokee Indians. This effort can only be achieved by the staff of all the hospital departments and support services working together for the concern and welfare of the Indian population. The Cherokee Service Unit Plan is to strive to develop and maintain a comprehensive health care system which will improve the health of all its recipients.

Since the inception of the United Southeastern Tribes, Inc. and the development of an Indian Health Service Staff, the Cherokee Service Unit has experienced an expansion of health care and program activities. It is expected that the added and increased services and programs, such as Community Health Representatives, Otitis Media, Nurse Aide Program, Health Coordinator, and Alcoholism and Mental Health, there will be a greater utilization of present hospital services and Tribal resources.

Plans for the coming years which will help the Cherokees to develop an improved and more comprehensive health system include; the planning, construction and occupation of the Snowbird Clinic and the plans for a total new health facility on the Qualla Boundary near the location of the present Cherokee Service Unit. The Tribal officials are to be commended for their immense effort to obtain funds for such a facility.

I wish to express my appreciation for the cooperation of the staff and those individuals who have worked so diligently and effectively to complete this plan. I am pleased with the professional attitude of the staff in formulating this useful document and commend them for a job well done.

Fredrick J. Bradley
Service Unit Director

PREFACE

This program plan has been prepared with the purpose: to provide comprehensive and quality health service for the Cherokee's by identifying and meeting their health needs as they have surfaced this recent year and then translated into the plans of action for Fiscal Year 1976-1977; to attempt to develop each individual staff member to his maximum potential for contribution to the quality of health care services.

In this program we will find three chapters, general data which gives us the general information about Cherokee area and its contents, program descriptions, and operational plans of twelve disciplines. In addition, there are some tables and figures which will give more clarification of narratives.

The accomplishment of this program plan was the combined efforts of all disciplines and agencies who are concerned with the welfare of the Cherokees.

I take this opportunity to express my appreciation for the cooperation of: the Service Unit Director, the members of the committee, other service unit staff, Tribal members, Tribal employees, the guidance counseling department of Cherokee High School and other agencies.

I am especially indebted to two Indonesian students of the University of Tennessee, who are here receiving their field training in health education, and for their invaluable assistance in this project.

I, also, wish to thank all of those who have contributed significantly to this program plan.

Ruth Taylor, Community Health Educator
Chairman, Program Planning Committee

Chapter I: Community Profile

History

Culture

Geographic Data

Population

Economy

Education

Communication

Transportation

Housing

Shopping and Recreation

Consumer Involvement

Tribal Health Board

Hospitalization

Available Health Resources

HISTORY OF THE EASTERN BAND OF CHEROKEE INDIANS

At the beginning of the nineteenth century, a tribe of people, calling themselves Yun-wi-yuh, meaning "Principal People", were the most civilized of all the North American Indians. The name Cherokee has been given many interpretations.

The Cherokee and the United States negotiated and signed many treaties. Indian History states that the United States broke these treaties with the Cherokee, and the Cherokee was always the loser.

The Cherokee possessions at one time, extended over a territory of fifty-three thousand (53,000) square miles which covered half of Tennessee, Alabama, and Georgia, and some portions of Kentucky, South Carolina, and North Carolina. In 1785, it was estimated there were sixty-four villages and towns. The Cherokee's were not recognized as citizens of the United States, so, therefore, they could not hold the land.

In 1838, General Winfield Scott was ordered by Congress to move the Cherokee to the West. This march was made under military escort. Many Cherokee died on the way to Oklahoma. The mass exodus, one of the most dismal pages in American History, is enough to startle and shame an average American even to this day. The Cherokee were highly civilized, intelligent, honest and sincere. According to actual records, these people were the most law-abiding and peaceful residents of the whole mountain area. Yet they were herded into stockades where they were held for weeks before being marched nearly a thousand miles into a section of Oklahoma called the "Cherokee Nation".

The present day Cherokee are descendents of one tribe, those making the march of the "Trail of Tears" to Oklahoma are called Western Cherokee and the few that were left behind or refused to go, or went part-way and returned, are called the Eastern Band of Cherokee Indians.

It was not until July 29, 1848, that the first recognition by the Government of the United States to the rights of Indians was made.

Shortly after the removal of the Cherokee to the West, W. H. Thomas a friend and advisor to the Cherokee set out to purchase the Qualla Boundary, comprising a large track in Western North Carolina. With the support of Yonaguska, Principal Chief, Thomas was adopted into the Cherokee Tribe as his son, and given the name Will - Usdi. In 1938, Yonaguska dies and Usdi was elected to the position of Chief, the only white man so honored among the Cherokee Indians.

Usdi acquired funds from the individual Indians as well as many other sources and bought the land where the handful of Cherokee now reside. This purchase in 1866 had been approved by the Government of the United States.

In 1866, the state of North Carolina recognized the Eastern Band of Cherokee Indians, and in 1889, the North Carolina General Assembly granted a Charter to the Band.

The Cherokee found themselves involved in several law-suits pertaining to land titles between the years 1870 and 1890. In 1890, about 40,000 acres of the Qualla Boundary was sold for taxes. In 1892, an appropriation was made by Congress for redemption. In 1924, the title was conveyed to the United States for protection, and on July 21, 1925, the land of the E.B.C.I. was put in the trust of the Federal Government, the Unites States still holds the deed to Qualla Boundary; land originally purchased from the state of North Carolina by the Eastern Band of Cherokee's and their friends.

An amendment to the Charter grants the Eastern Band of Cherokee Indians the responsibility of its own Tribal Government which is modeled after the American Constitution. The Tribal Government consists of the Council, an elected body of twelve representatives, two from each township that makes up the reservation. These elected officials serve for two years. The Tribal Council is basically a legislative body. The Executive Department consists of an elected principal chief, an elected vice-chief, and an executive advisor. The executive advisor is appointed by the principal chief, and this appointment is ratified by the Tribal Council. The executives are elected to serve for four years.

Cherokee looks forward with anticipation to the future; a future which hopefully will be filled with activities and accomplishments. With planned determination the Cherokee continue to set an outstanding example of the "Principal People" they were in the beginning.

CULTURE

Because the Cherokee lived so close to the white man, and as a consequence of wanting what was good of what their neighbors had, the Cherokee rapidly accepted the white man's garb in exchange for the beads, furs, and other unique items. This seems to be the general trend, even today, because of tourism on the reservation.

The Cherokee home is improving, but still much work needs to be done in housing for the Indian people. There are three areas on or near the reservation where one may visit caves once used by the Indians as dwellings.

Cherokee is now being taught to young people in the schools. Sequoyah, a noted Cherokee scholar, devised an alphabet and written language and his people very quickly became literate in their ancient tongue; very few, if any tribes, have such a written language. Many songs are still sung in the Cherokee language.

Indian men dress like any other American male, and the Indian women have adopted fashions of the day as worn by the white woman. However, many of the older women wear floor length skirts, and many of the older people wear the red handkerchief tied around their heads. It is possible to see a Cherokee baby comfortably riding on his mother's back.

As among many other Indian tribes, at Cherokee we have serious social and health problems due to alcohol, which has indeed been a curse and a blight to Indian culture.

Traditional Indian crafts play an important role in the income of the Cherokee. These traditional baskets, pottery, carvings, and weavings are among the finest. Many of the tribal members cling to the medicine man with his herbs and other home remedies.

There are many edible greens in the mountains, many only the Indian recognizes. Ramps are among the favorite green. The Cherokee women cook bean bread, which is pounded corn and boiled beans wrapped in fodder. This is most delicious. The dietary patterns in many respects have not changed in several generations.

The Cherokee still has an Indian ballgame ritual. The conjure man still chases the players, the center man first, then the fastest man with courage. The second man wears the feather of a raven. The strong men wear the feather of an eagle. Other players wear the feathers of the goose. Two drivers, one from each team, carry long keen switches; this keeps the players going because nothing is barred! The team that makes 12 points first wins. After the game, the women feed the players and visitors. Seven days later

the winning team, day and night, come together for tribal dances. A friendship dance is performed for the victory celebration.

The Cherokee's have seven clans, each tribal member knowing his own clan. We have thirty-eight churches on the reservation, with nine different denominations. Baptists lead in membership, with most of the people embracing the protestant faith.

In other respects, our culture has become more like that of our non-Indian neighbors, a mixture of mountain and urban life styles.

GEOGRAPHY

The Eastern Band of Cherokee Indian land is located near the Great Smoky Mountain National Park in North Carolina, and includes a total of 56,572.80 acres of land; 49,784 acres (88%) of which is forest land unfit for other general purposes and only 6,789 acres useable for homes, business, roads, schools, farms, etc. About half of this useable acreage, a total of 3,003 acres, is currently used for roads, businesses, industry, government, social culture, recreation, utilities and landfills, churches, and farm fields. Of residential land use, there is approximately 1,857 acres currently in use.

Due to the rugged, mountainous terrain with grossly inadequate road system, our Cherokee people have been unable to participate in economic and cultural advances made by the nation as a whole. In a position of relative isolation from the main stream of life in the United States, the people have been unable to benefit from many of the established state programs.

Oconaluftee River is the only river which flows in the Eastern Band of Cherokee Indian land. Formerly, this river was very clean, but with the development of tourism, it is likely that this river will become more polluted.

The Eastern Band of Cherokee Indian land (reservation) is located mainly in Swain and Jackson counties, as indicated from the following number:

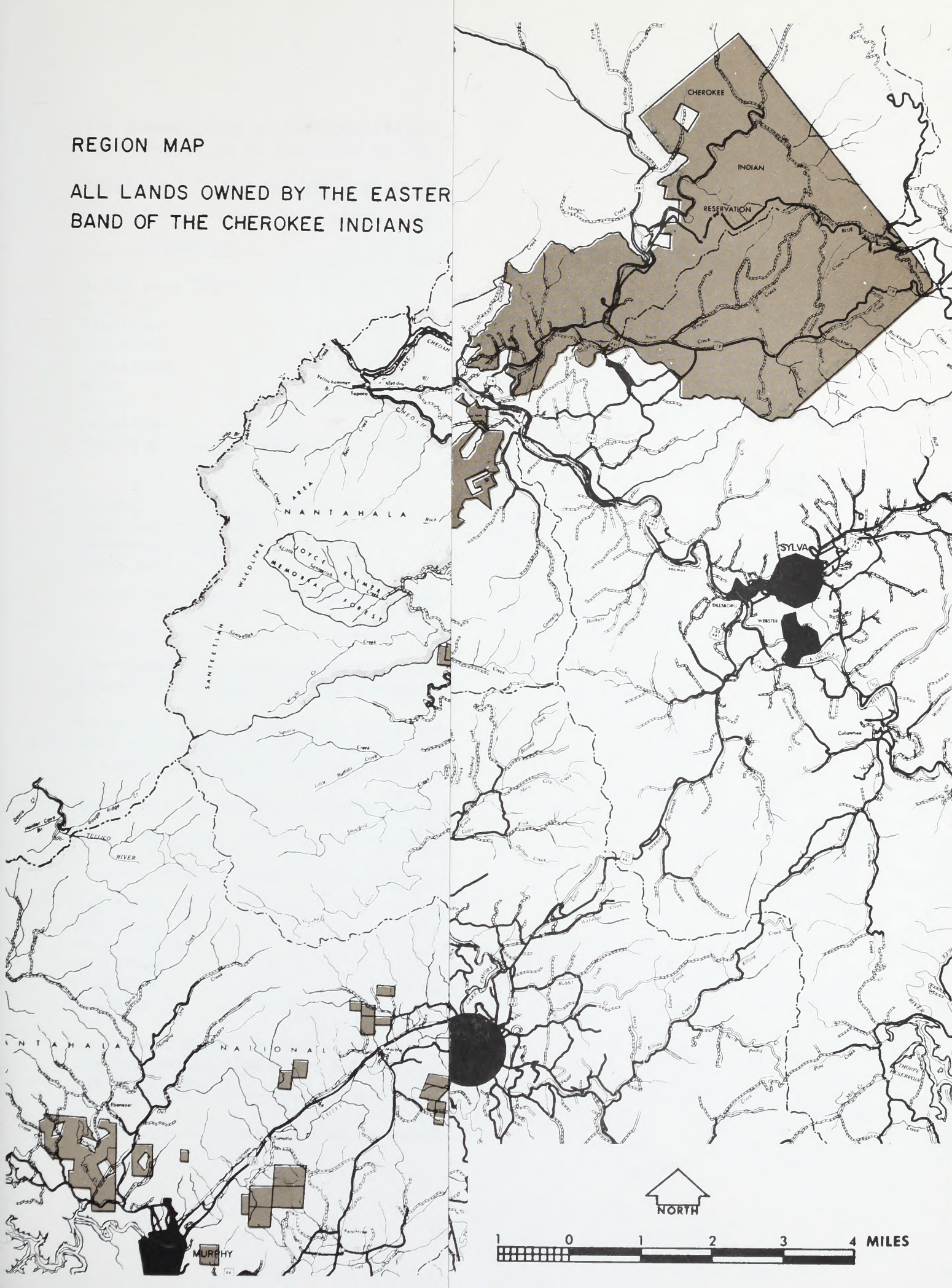
TABLE 1: TOTAL AREA OF EASTERN BAND OF CHEROKEE INDIAN BY COUNTY

County	Acres
Cherokee	5,571
Graham	2,249
Haywood	80
Jackson	19,267
Swain	29,409.80
TOTAL	56,572.80

Map Number 1 shows the location of all lands owned by the Eastern Band of the Cherokee Indians

REGION MAP

ALL LANDS OWNED BY THE EASTER
BAND OF THE CHEROKEE INDIANS



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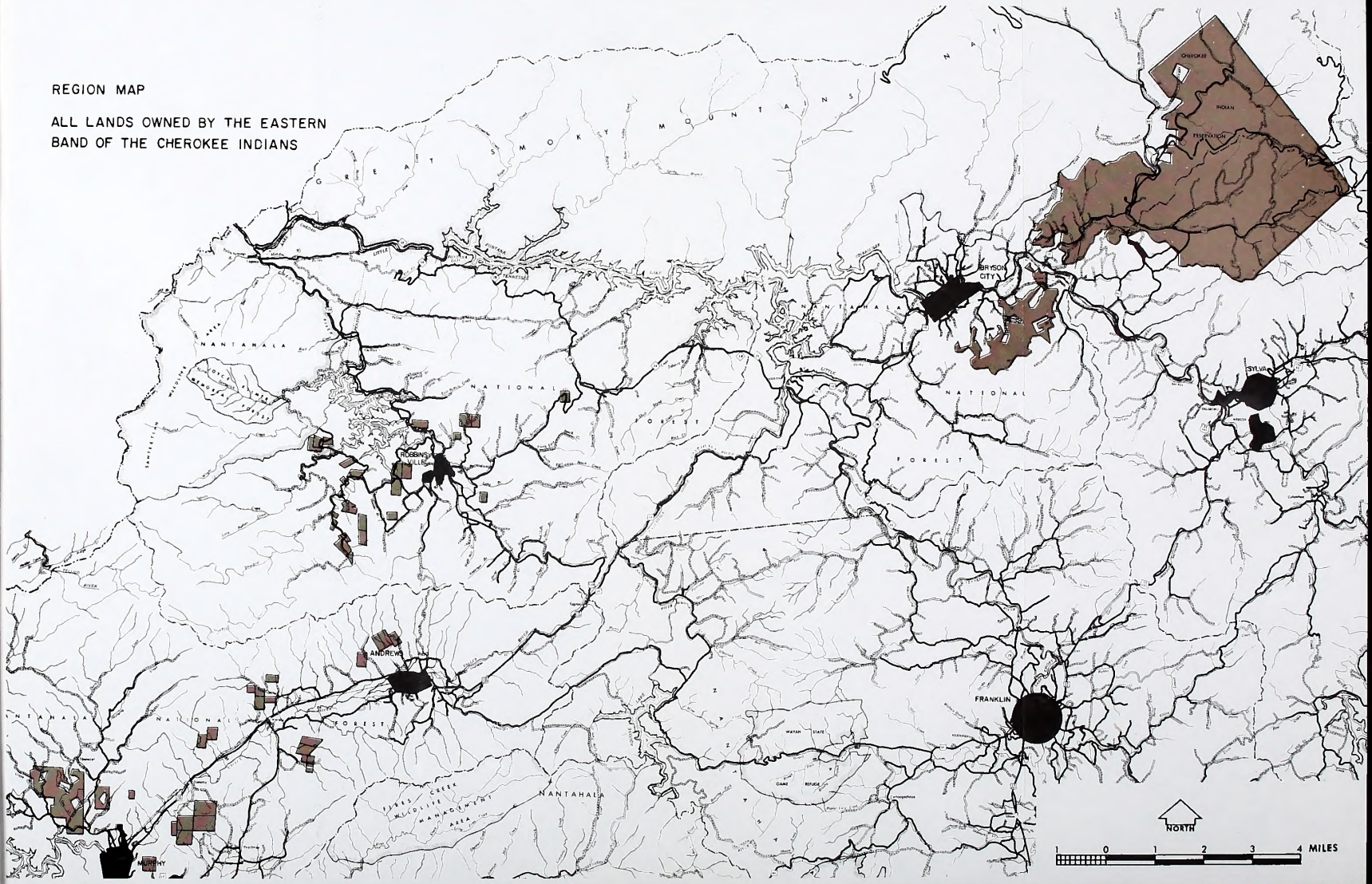


The Eastern Band of Cherokee Indian land is also divided into several community areas as indicated in the following table:

TABLE 2: THE EASTERN BAND OF CHEROKEE INDIAN LAND

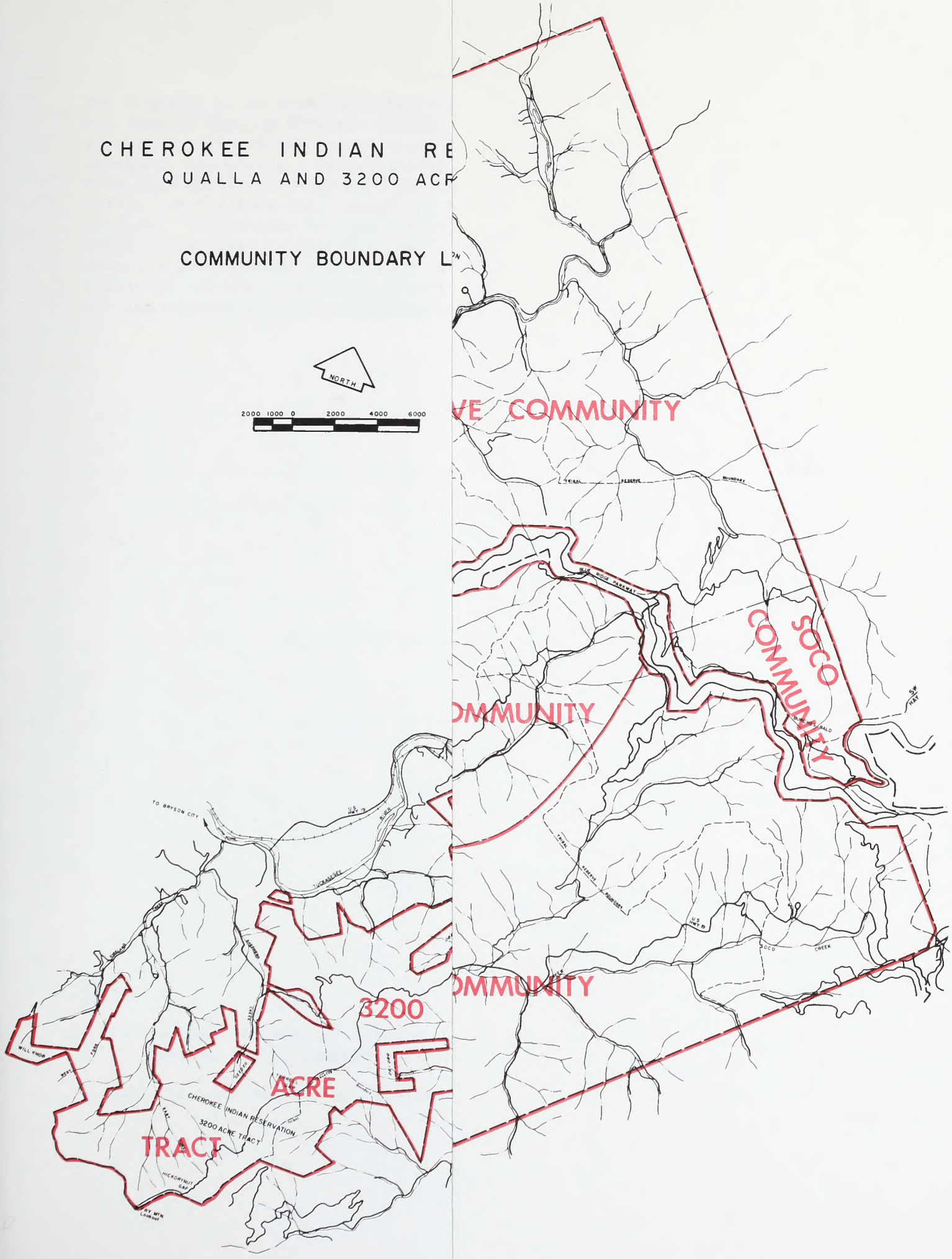
Community	County	Total Acreage
3,200 Acre Tract	Swain	3,200
Big Cove	"	13,911
Birdtown	"	4,422
Cherokee	"	3,852
Painttown	Jackson	3,019
Soco	"	13,233
Big Y	"	3,010
Snowbird	Graham	2,249
Cherokee County Tracts	Cherokee	5,571
	Sub-total	52,472
State, Federal, and BIA roads	1,059	
Blue Ridge Parkway	1,320	
Government-owned	129	
Other use	1,593	
		4,101
	TOTAL	56,573

The boundary of those communities, except Snowbird and Cherokee County Tracts can be seen from Map Number 2.

As we can see from Table 3, there are six townships within the Eastern Band of Cherokee Indians, namely Big Cove, Birdtown, Yellow Hill, Wolfetown, Painttown and Snowbird.

TABLE 3: TOWNSHIPS AND LAND WITHIN THE EASTERN BAND OF CHEROKEE INDIANS

Township	County	Acreage
Big Cove	Swain	13,911
Birdtown	"	7,622
Yellow Hill	"	3,852
Wolfetown	Jackson	16,248
Painttown	Jackson	3,019
Snowbird	Graham	7,820
	Sub-total	52,472
Government Owned, Federal, State and BIA roads, Blue Ridge Parkway and other use		4,101
	Total	56,573


CHEROKEE INDIAN RE
QUALLA AND 3200 ACR
COMMUNITY BOUNDARY L
NORTH
2000 1000 0 2000 4000 6000
VE COMMUNITY
SOCO COMMUNITY
OMMUNITY
OMMUNITY
3200 ACRE TRACT
CHEROKEE INDIAN RESERVATION
3200 ACRE TRACT
TO BRYSON CITY
U.S. HWY 19
U.S. HWY 19
TRIBAL RESERVE BOUNDARY
BLUE RIDGE PARKWAY
SOCO CREEK
WILL KNOB
HICKORYNUT GAP
RY. MTN.


CHEROKEE INDIAN RESERVATION
QUALLA AND 3200 ACRE TRACTS
COMMUNITY BOUNDARY LINES
BIRDTOWN COMMUNITY
CHEROKEE COMMUNITY
BIG COVE COMMUNITY
BIG "Y" COMMUNITY
PAINTOWN COMMUNITY
SOCO COMMUNITY
SOCO COMMUNITY
3200 ACRE TRACT
INDIAN RESERVATION

The township is an administrative and governmental division of the Eastern Band of Cherokee Indian land. Each township has two representatives in the Tribal Council. All these townships except Snowbird, are within a comparatively few miles of Governmental and Community Service Centers such as the BIA Office, Tribal Government Office and the hospital. Snowbird is about 40 to 50 miles from these centers. In addition to those townships, there are several other small communities in Cherokee County which are about 65 miles from the governmental and service centers. These distances make it difficult for the government as well as community services to serve all the members of these scattered communities.

Source

- Eastern Band of Cherokee Indians: Land Use Analysis and Initial Housing Study, Comprehensive Plan Volume IV, August 1974

- Qualla Housing Authority: Housing Development, memeograph

POPULATION

The population of the Eastern Band of Cherokee Indians has been broken down into the following category:

1. Enrolled Eastern Band of Cherokee Indians (Reservation & non-Reservation)
2. Enrolled Eastern Band of Cherokee Indians living on Tribal owned lands
3. Enrolled Eastern Band of Cherokee Indians living off the Tribal lands.
4. Non-Indian (dependent of Indian) living on Eastern Cherokee Tribal owned land (usually married to an enrolled Eastern Cherokee).

There are several sources about population data, each giving a different number:

1. U.S. Population Census 1970
2. A house to house survey, conducted by the Aid to Tribal Government Program in 1972
3. Tribal Enrollment Office, which gives the enrollment number in January 1975

Total Population on Eastern Band of Cherokee Indians land:

According to U.S. Population Census in 1970, the total population of EBCI was 3,211 with the distribution as follows:

Population Distribution by County
U.S. Population Census, 1970

County	Total Population
Cherokee County	79
Graham County	320
Jackson County	1,819
Swain County	993
Total	3,211

The house to house survey, conducted by the Aid to Tribal Government Program in 1972 records the number at 5,030 people (Eastern Band of Cherokees) living on Eastern Band of Cherokee Indians lands (Reservation).

According to the Tribal Enrollment Office, in January 1975, the numbers of the Eastern Band of Cherokees were as follows:

Total Enrolled Eastern Cherokee Indians	8,381
Enrolled members residing off EBCI lands	2,831
Enrolled members residing on EBCI lands	5,550

However, we feel the number given by the Tribal Enrollment Office is the most accurate, because this census was an actual count of every Eastern Cherokee Indian and this census is the latest one. For our purpose, we will always use this number.

Population Distribution by Community

There are nine communities within the Eastern Band of Cherokee Indians lands; the total population, (Eastern Cherokee Indian), and the total land area of each community as shown in Table 4.

TABLE 4: POPULATION DISTRIBUTION BY COMMUNITY
TRIBAL ENROLLMENT OFFICE, JANUARY 1975

No.	Community	County	POPULATION Male	Female	Total	Acreage of Land
1.	3200 Acre Tract	Swain	90	93	183	3,200
2.	Big Cove	Swain	357	353	710	13,911
3.	Birdtown	Swain	573	514	1,087	4,422
4.	Cherokee	Swain	439	457	896	5,571
5.	Painttown	Jackson	398	390	788	3,852
6.	Soco	Jackson	443	443	886	13,238
7.	Big Y	Jackson	218	192	410	3,010
8.	Snowbird	Graham	212	212	424	2,249
9.	Cherokee County Tract	Cherokee	85	81	166	4,422
	TOTAL		2,815	2,735	5,550	52,573

Seven of those nine communities are located in Swain and Jackson Counties; Map No. 3 shows population concentration in those seven communities. Map No. 4 shows population concentration in the Cherokee County Tract, while Map No. 5 shows population concentration in Snowbird Community (Graham County).

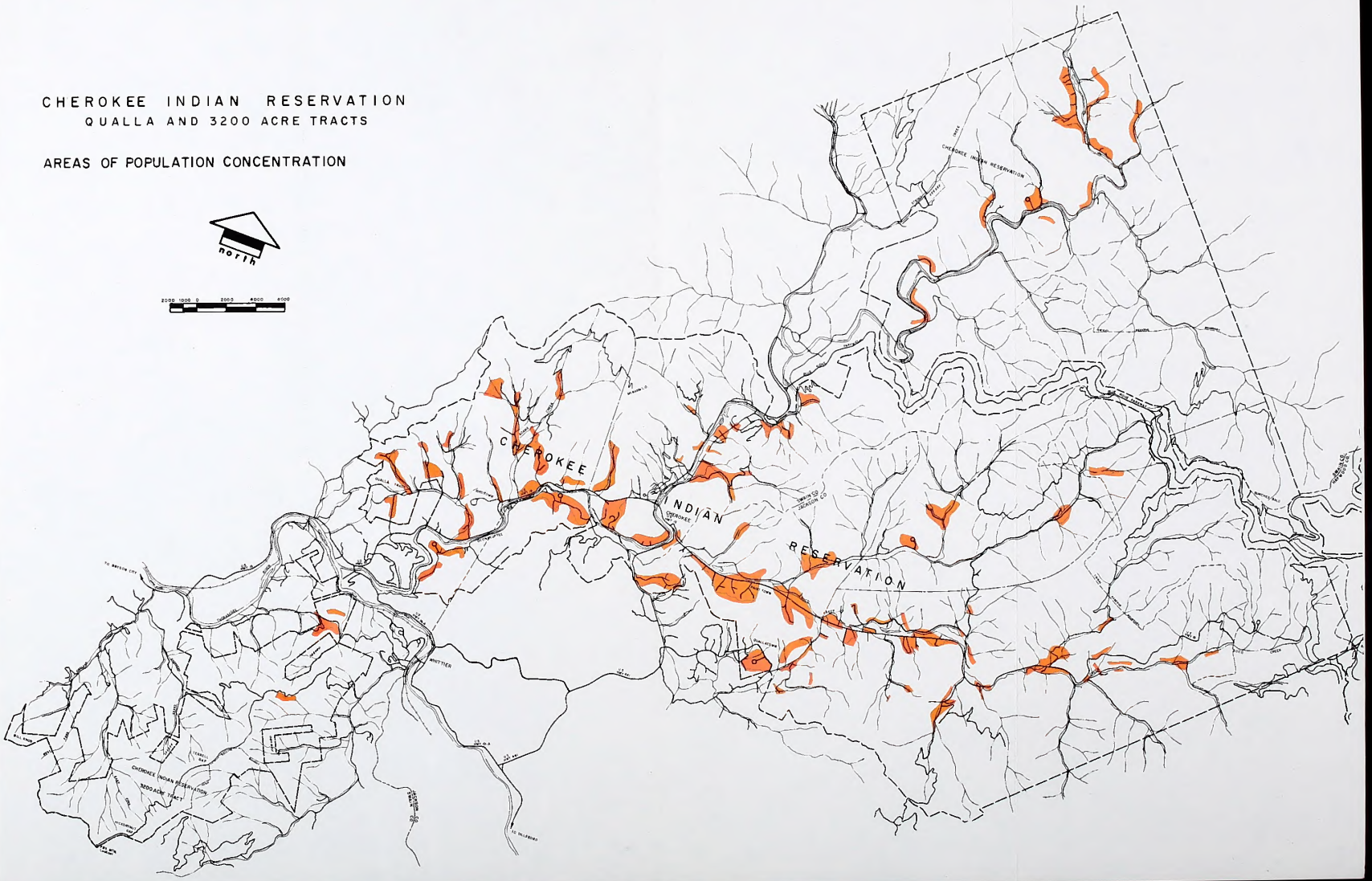
Population Distribution by Age Group

Table 5 shows the population distribution by age of the Eastern Band of Cherokee Indians.

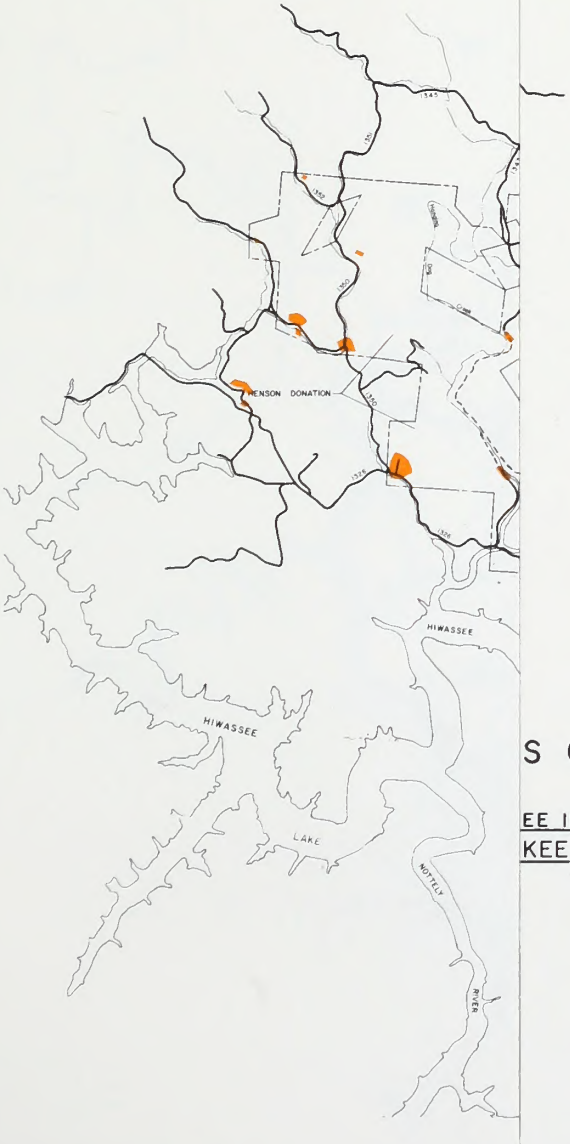
CHEROKEE INDIAN RESERVATION

QUALLA AND 3200 ACRE TRACTS

AREAS OF POPULATION CONCENTRATION

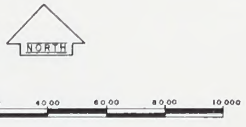



AREAS OF POPULATION CONCENTRATION
CHEROKEE INDIAN TRACTS
CHEROKEE COUNTY, N.C.
NORTH
ANDREWS
MURPHY
HIWASSEE
LAKE
RIVER
VALLEY



S OF POPULATION CONCENTRATION

EE INDIAN TRACTS
KEE COUNTY, N.C.




AREAS OF INDIAN POPULATION CONCENTRATION
CHEROKEE INDIAN TRACTS
(SNOWBIRD)
GRAHAM COUNTY, N.C.
NORTH
SANTEETLAH
LAKE
NANTAHALA NATIONAL FOREST
ROBBINSVILLE
MILLTOWN
CHEOAH
RIVER
APPALACHIAN
TRAIL
TRACT - 92
TRACT - 87
TRACT - 88
TRACT - 103
TRACT - 90
TRACT - 482
TRACT - 364
TEEOATLAH
TRACT - 477
TRACT - 93
TRACT - 91
TRACT - 373
TRACT 368
TRACT - 17
TRACT - 37
TOM KALONUHESKA
TRACT - 374
TRACT - 365
TRACT - 481
JESS TEESETESKA
TRACT - 589
TRACT - 367
TRACT - 588
TRACT - 405
TRACT - 404
SNOWBIRD
CREEK
SENIC R.R.
U.S. 129
Sweetwater
Mountain
Long
Branch
Hunting
Boy
Aloah
Bert
Creek
-2000
0
2000
4000
6000
8000
10000

TABLE 5: Population Distribution by Age Group
Tribal Enrollment Office, January 1975

Age	Total	Male	Female
0 - 4	538	267	271
5 - 9	605	330	275
10 - 14	707	372	335
15 - 19	638	305	333
20 - 24	540	265	275
25 - 29	476	253	223
30 - 34	357	191	166
35 - 39	316	145	171
40 - 44	252	118	134
45 - 49	221	114	107
50 - 54	199	101	98
55 - 59	196	97	99
60 - 64	172	82	90
65 - 69	134	65	69
70 - 74	93	58	35
75 and over	106	52	54
Total	5,550	2,815	2,735

Table No. 6 shows the population distribution by age group in each community within the Eastern Band of Cherokee Indian's land. However, there is much migration from the Eastern Band of Cherokee Indians' land to other places, especially among young people (about 30 years old), as indicated from the population graph 1.

Birth and Death

According to the Tribal Enrollment Office, in 1974 there were 124 births and 21 deaths on the Eastern Band of Cherokee Indians lands. Therefore, if the population in January 1974 = 5,550 - 124 + 21 = 5,447 (excluding migration), the birth and death rates can be compiled in the following manner:

1. The birth rate on EBCI land in 1974 = $\frac{124}{5447} \times 1{,}000 = 22.76$

2. The death rate in 1974 = $\frac{21}{5447} \times 1{,}000 = 3.85$

However, those birth and death rates need to be compared with the birth and death rates prior to 1974. Although there was no exact population figure in each year prior to 1974, a calculation can be done, if it is based on:

a. The total population of 5,550 in January 1975
b. The existing record of birth and death each year (from 1963 to 1974)
c. Migration (in and out) is excluded

TABLE 6
ENROLLED MEMBERS OF THE EASTERN BAND OF CHEROKEE INDIANS
As of January, 1975

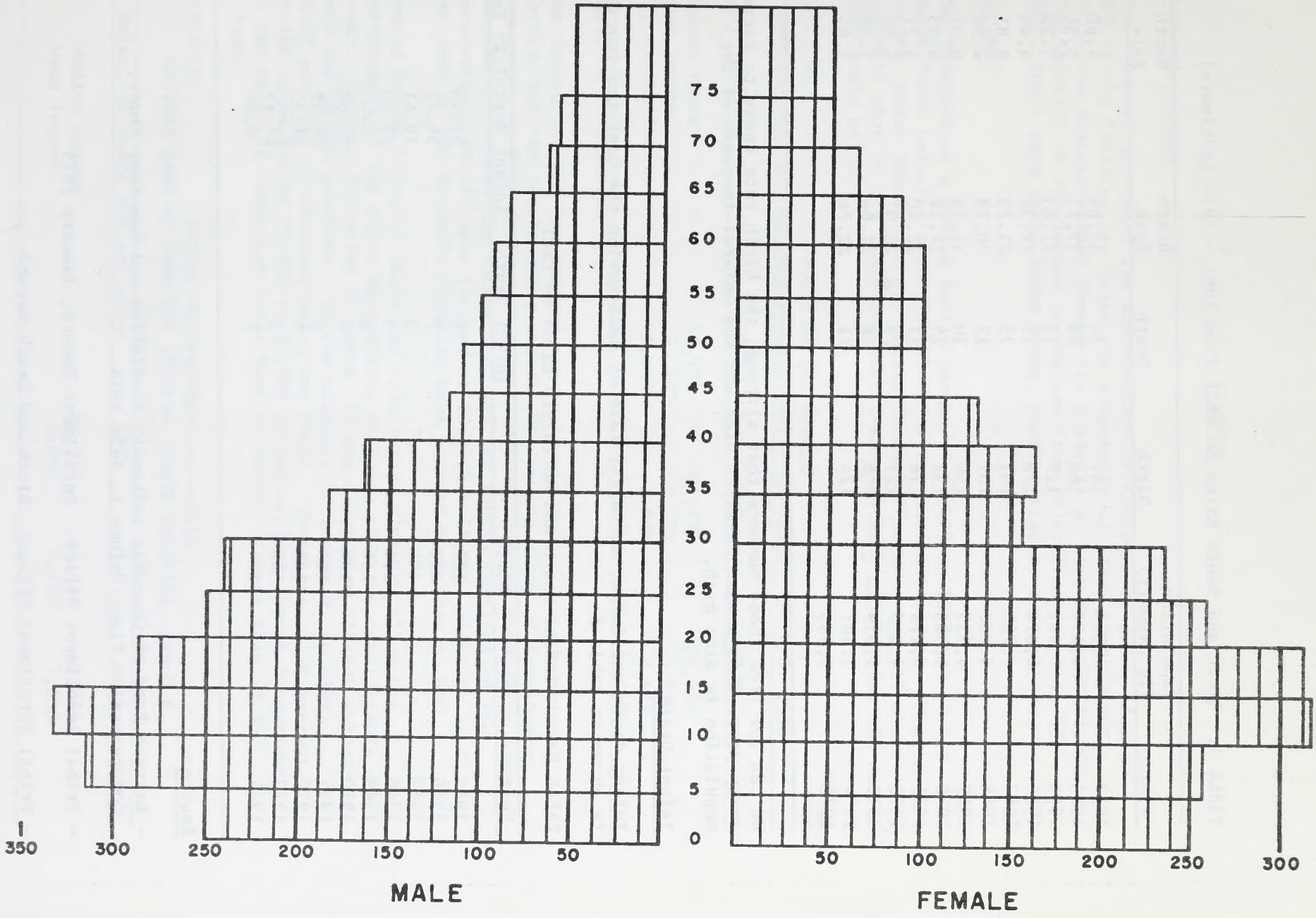
COMMUNITY		AGES																TOTAL
		0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	
Soco	M	48	56	40	44	47	52	32	22	19	21	14	15	14	8	4	7	443
	F	47	49	60	57	53	36	23	25	17	14	15	8	10	11	7	11	443
Big Y	M	29	22	47	17	21	18	12	12	6	8	5	6	3	6	4	2	218
	F	26	20	20	29	16	16	12	14	7	11	3	6	7	3	1	1	192
Painttown	M	20	40	65	58	36	26	30	24	17	18	11	14	16	13	7	3	398
	F	20	37	60	49	43	33	24	22	32	14	9	14	13	11	5	4	390
Birdtown	M	59	77	78	60	54	45	35	26	35	20	14	17	13	9	19	12	573
	F	59	45	70	64	52	38	34	37	24	14	21	19	12	9	9	7	514
3200 Acre	M	7	16	11	13	6	7	4	4	4	4	7	1	2	1	2	1	90
	F	10	13	8	6	7	10	3	3	6	9	6	2	4	2	2	2	93
Cherokee	M	49	45	47	44	44	43	40	29	12	15	12	14	13	13	7	12	439
	F	47	43	43	43	44	50	40	31	18	16	19	22	21	9	3	8	457
Big Cove	M	35	46	45	43	37	38	20	17	10	11	16	13	9	3	6	8	357
	F	47	39	46	57	37	19	15	17	16	15	11	7	10	6	4	7	353
Snowbird	M	20	28	37	20	15	20	12	9	11	10	11	6	6	0	4	3	212
	F	15	26	27	24	17	15	10	15	12	9	6	9	9	9	2	9	212
Cherokee	M	0	0	2	6	5	4	6	2	4	7	11	11	6	12	5	4	85
County	F	0	3	1	4	6	6	5	7	2	5	8	12	6	9	2	5	81

TOTAL 5,550

Members Residing Off the Reservation---------- 2,831

8,381

POPULATION DISTRIBUTION BY AGE
E.B.C.I. JANUARY 1975



GRAPH 1

SOURCE : TRIBAL ENROLLMENT OFFICE

TABLE 7: Birth and Death Rates on EBCI from 1963 - 1974 (estimate)

Year	Population (in January)	Birth	Death	Birth Rate	Death Rate
1963	4,343	147	20	33.84	4.60
1964	4,470	166	24	37.13	5.36
1965	4,562	127	15	27.83	3.28
1966	4,674	128	21	27.38	4.49
1967	4,781	102	23	21.33	4.81
1968	4,860	101	22	20.78	4.52
1969	4,939	156	30	31.58	6.07
1970	5,065	138	25	27.24	4.93
1971	5,178	116	27	22.40	5.21
1972	5,267	121	29	22.97	5.50
1973	5,359	116	28	21.64	5.22
1974	5,447	124	21	22.76	3.85
1975	5,550				

We can see from those numbers that although the birth rate tends to decrease every year, this number is still high and the natural increase of the population is also high.

Infant Death

Infant death and infant mortality rate of EBCI during the last ten years is shown in Table 8:

TABLE 8: Infant Death and Mortality Rates on EBCI

Year	Birth	Infant Death	Infant Mortality Rate
1965	127	4	31.49
1966	128	7	54.77
1967	102	3	29.41
1968	101	3	29.70
1969	156	0	---
1970	138	4	28.98
1971	116	4	34.48
1972	121	5	41.32
1973	116	2	17.24
1974	124	1	8.06

Source:

- Eastern Band of Cherokee Indians: Population and Ecnonomy Study, Comprehensive Plan, Volume I, July 1974

- Tribal Enrollment Office: Enrollment Record, January 1975

- Tribal Enrollment Office: Birth and Death Record

ECONOMY

Economic Status:

The economic status of the Eastern Band of Cherokee is poor. Almost 80% of the families are below the poverty level (less than $3,000) while the average annual income for a family of four is about $3,000. The majority of the income is derived from Federal employment, OEH ONAP, local wage work, lease money, tourist trades, and welfare.

Income:

The Reservation's median family income of $4,125 in 1970 was $3,649 below North Carolina's and $5,461 below the national median. Median income, means income and per capita income of persons are all about one-half that of the state and much less than half of that for the nation. (See table below)

TABLE 9: INCOME OF THE PEOPLE
EASTERN BAND OF CHEROKEE INDIANS, NORTH CAROLINA, AND U.S. 1970

All Families	EBCI	N.C.	U.S.
Median Income	$4,125	$7,774	$9,586
Mean Income	4, 743	8,229	10,930
Per Capita Income	1,034	2,888	3,687

Based on 1970 Census

One reason for the low incomes can be traced to the low educational levels, and the accompanying impediments to the kinds of development conducive to high paying industry locations, and the dependence upon tourism activities for income. Of all the Indian families on the Reservation, 62.24% have incomes of less than $5,000, although 84.35 per cent of the nation's families have incomes more than $5,000.

Female income (ages 16 years and older) more closely follow the percentages of the state and nation, although they are considerably lower. Incomes for males 16 years old and older show violent swings into low income brackets. In the category of income $1 to $999, 26.38 per cent of Cherokee males are found. There are 17.46 percent of the males in the $2,000 to $2,999 income scale. Almost 54 percent of the males 16 years and older have an income of less than $3,000 a year.

TABLE 10: INCOME OF PERSONS--------MALE
EASTERN BAND OF CHEROKEE INDIANS, NORTH CAROLINA, AND U.S.
(Census 1970)

Males, 16 years old and older	EBCI	N.C.	U.S.
Median income	$2,372	$4,824	$7,774
Mean Income	2,664	5,748	7,600

The data received indicates a small rise in per capita income.

TABLE 11: PERCENTAGE INCOME PER CAPITA OF EBCI In 1973-1974

Year	Percent of Labor Force Employed	Per Capita Income
1973	90.0%	$2,163
1974	89.0%	2,399

Taken from the Annual Council Report, October 1974

Economic Developments:

One of the most important aspects of the Cherokee Agency is directing the economic growth of the Eastern Band of Cherokee Indians.

Because of its geographic location, the Cherokee Reservation is not attractive to heavy industry; therefore, the economic growth must depend on light industry, visitor attractions and the proper use of natural resources. The underdevelopment of human and natural resources, in which we do not have an adequate reservoir of trained people with marketable skills, has created a climate of poverty in which there is an established pattern of long range dependence on welfare assistance in a relatively large segment of our population. Lack of employment opportunity has led to the "out migration" of young people who do have marketable skills.

General Poverty:

Although the Cherokee's have done much to increase the standard of life on Cherokee Reservation, with the poverty status of 54.99 percent of the total individual inhabitants existing with incomes less than the poverty level, while for North Carolina and the United States levels were 16.80 and 16.75 percent. Then with 52.17 percent of all the families with incomes less than poverty level, compare to North Carolina and the Nation, 16.50 and 10.70 percent (See graph Number 2).

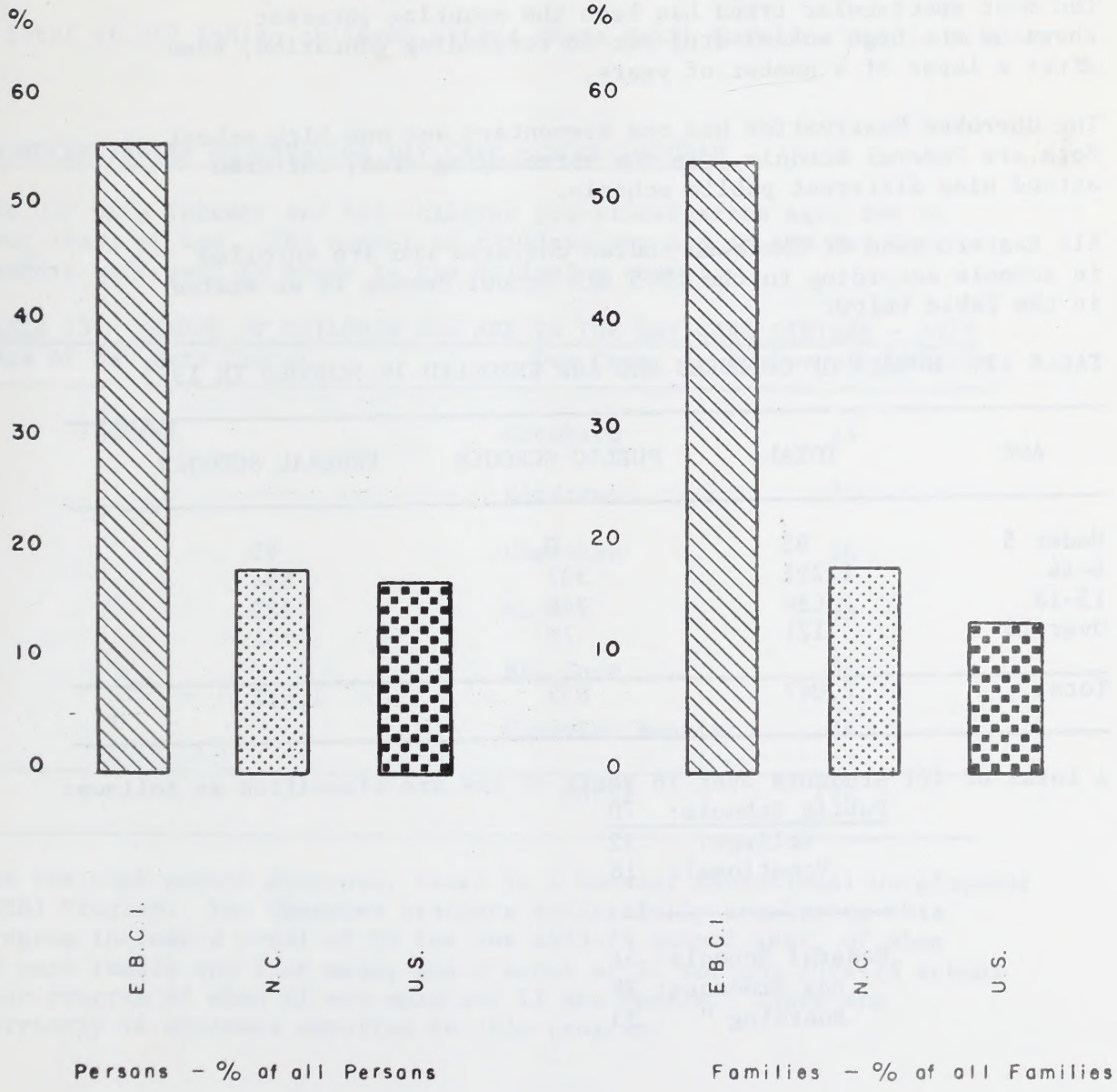
It is obvious that dynamic improvements on the economy will have to take place in order to provide the minimum of necessities, comforts and luxuries, that is essential if the Cherokee's are to attain equal monetary status as determined by non-Indians.

Graph Number – 2

POVERTY STATUS OF THE POPULATION

EASTERN BAND OF CHEROKEE INDIANS, NORTH CAROLINA & THE UNITED STATES, 1970

INCOME LESS THAN POVERTY LEVEL



EDUCATION

Educational opportunities for the Eastern Band of Cherokee Indians have been available for many years. (The extent that the people have taken advantage of this opportunity may be evident in other sections of this profile, as will be noted under sections on economics and housing.)

In the recent past, impressive gains in those interested in education can be noted in the number of families placing children in our day care units. The interest shown by the parents in their elementary school children sets an all time high. The number of students completing high school has added new hope for our future. Those students going on to continued education in vocational and college have increased appreciably. The most spectacular trend has been the mounting interest shown by the high school drop-out in continuing education, even after a lapse of a number of years.

The Cherokee Reservation has one elementary and one high school. Both are Federal schools. In the surrounding area, children attend nine different public schools.

All Eastern Band of Cherokee Indian children who are enrolled in schools according to the 1975 BIA School census is as stated in the Table below:

TABLE 12: NUMBER OF CHILDREN WHO ARE ENROLLED IN SCHOOLS IN 1975

AGE	TOTAL	PUBLIC SCHOOLS	FEDERAL SCHOOLS
Under 5	95	0	95
6-14	1,221	337	884
15-18	630	248	382
Over 18	121	70	51
Total	2,067	655	1,412

A total of 121 students over 18 years of age are classified as follows:

Public Schools:	70
College:	52
Vocational:	18
Federal Schools:	51
Day Students:	28
Boarding " :	23

There are several public schools surrounding Eastern Band of Cherokee Indians which Indian children attend. These include:

Scotts Creek---------6
Almond---------------2
Qualla-------------102
Whittier-----------64
Robbinsville
Elementary--------66
Robbinsville
High School-------10
Swain County High
School------------35
Swain Elementary----46
Sylva Webster-------36

A total of 367 Indian children attend these North Carolina public schools.

CHEROKEE INDIAN RESERVATION DAY CARE SCHOOL PROGRAM

The Day Care Centers sre for children pre-kindergarten age, two to four years of age. The number of children who are in the Day Care Centers this year is shown in the following chart:

TABLE 13: NUMBER OF CHILDREN WHO ARE IN THE DAY CARE CENTERS - 1975

Type of Day Care Center	Day Care	Number of Children
Federal	Snowbird	15
"	Birdtown	25
"	Cherokee	28
"	Soco	38
"	Big Cove	35
"	Cherokee Baptist	36
	Total	177

For the high school drop-out, there is a General Educational Development (GED) Program. The Cherokee students successfully completing this program include a total of 19 for the 1973-74 school year, of whom 15 were female and four male; and a total of 22 for the 1974-75 school year program of whom 11 are male and 11 are female. There are currently 44 students enrolled in this program.

There is no current data on educational level of the adults on Cherokee Indian Reservation. Apparently the adult educational level in this area is a little lower than that of the state of North Carolina, as a whole, as well as the United States as a whole, as indicated by the following from the 1970 U.S. Census:

TABLE 14: YEARS OF SCHOOL COMPLETED
EASTERN BAND OF CHEROKEE INDIANS, NORTH CAROLINA, U.S. 1970

Years of School completed		Percentage of total of those 28 years & Older		
		EBCI	N.C.	U.S.
Elementary:	1 to 4 years	10.85	8.04	2.26
	5 to 7 years	22.20	18.34	10.04
	8 years	13.49	8.82	12.75
High School:	1 to 3 years	29.19	24.38	19.37
	4 years	18.34	21.65	31.08
College:	1 to 3 years	1.93	8.37	10.60
	4 years	0.43	5.54	6.07
No school years completed		3.57	1.97	1.61
Percentage of 25 years old and over for the total population:		40.55	52.07	54.08

COMMUNICATION

FACILITIES:

There are two radio stations located nearby in Sylva and Bryson City, but the reception from both radio stations is very poor in most areas of the Cherokee community. There is a need for a radio station on the Reservation.

Telephone service is available to all IHS facilities on the Reservation. There are 366 business phones and 1,157 residence phones on the Cherokee exchange. Approximately 50% of all the residential phones are in Indian homes.

Television which covers most of the Cherokee lands with all major networks, ha made it possible for most Cherokee people to be as instantly aware of happenings throughout the world as it is for people residing in the nations largest metropolitan areas.

Fortunately, Cherokee has a U.S. Post Office with rural route postal service and post office boxes.

For another communication purpose, there are police and ambulance communication systems which enable the people to call for and receive help quickly.

The nearest telegraph system is twelve miles away in Sylva, North Carolina.

PERSON TO PERSON COMMUNICATION:

The Cherokee people have the desire to be as informed as possible concerning the significant happenings in the local community and also in the nation's Indian community. To accomplish this, the Cherokee Tribal Council created an official tribal publication, THE CHEROKEE ONE FEATHER, in the mid-1960's. This paper which is heavily subsidized by the Tribal Council and other community citizens. It is normally published on a weekly basis in a four-page edition that is available at modest cost on either a subscription or newstand basis. The total circulation of the ONE FEATHER is 1,800 copies, consisting of 100 which are mailed out to Cherokee and Snowbird Communities; 1,100 to newstands; and 600 mailed off the Reservation.

Newspapers which can be found in Cherokee are:

Asheville Citizen- Daily newspaper
Asheville Times- Daily newspaper
Atlanta Journal- Weekly newspaper
Waynesville Mountaineer- Weekly newspaper
Smoky Mountain Times- Weekly newspaper

Sylva Herald- Weekly newspaper

Since reservation groups are relatively small, "the Moccasin telegraph" is a common form of two way communication among the Indian people themselves. Like most "grapevine systems," it is fast but characterized by distortions.

Most of the Indian people speak the English language, however, there are those who speak only the Cherokee language.

TRANSPORTATION

Adequate transportation is one of the keys of the development of any community or area. Eastern Band of Cherokee Indian land is located in the midst of the heart of the Southern Appalachian Region, which has been one of the slowest in the nation to develop and adequate system of roads.

Being a very popular tourism resort, Cherokee is visited by millions of people each year. It is unfortunate that some of the roads leading to this area are still in poor condition. Although road improvements are being made every year, the arteries into Cherokee are still narrow, crooked and unable to bear the volume of traffic which comes this way, especially during the summer.

Since the Indian people and communities on the Eastern Band of Cherokee land are very scattered within four counties (Cherokee, Graham, Jackson, and Swain) the transportation and communication between these communities, the governmental and service centers, (such as Tribal Government, Bureau of Indian Affairs, and Hospital) as well as business centers is very important.

The only public transportation passing through Cherokee is the Continental Trailways Bus. By using this bus, Cherokee people can go to other places, such as Chattanooga and Waynesville. However, the schedule of this bus is very poor. There is also a local bus that travels over the reservation area; this local transportation is managed by the Community Action Program. Fortunately, the Boy's Club contracts bussing service to the Bureau of Indian Affair's School for school transportation. This Club also offers a chartered bus service.

It is estimated that every two households on the Reservation have one car. Some of these cars are of old and poor condition. Concerning the existing cars as a comparison with North Carolina as a whole, and the United States as a whole, U.S. Population Census 1970 gives the following table:

TABLE 15: AUTOMOBILES AVAILABLE, EBCI, NORTH CAROLINA, AND U.S. 1970

Automobiles	Percent of Total Household		
	EBCI	North Carolina	U.S.
1	45.10	44.90	47.71
2	10.78	32.49	29.32
3 or more	1.72	5.58	5.51
None	44.12	17.02	17.47

HOUSING

A survey done by the Department of Natural and Economic Resources in cooperation with the Aid to Tribal Government Program, the Economic Development Administration Staff in Cherokee, and the Qualla Housing Authority, in February 1974, indicated there were 1,263 dwellings located in the land owned by the Eastern Band of Cherokee Indians. The total and condition of these housings in each community is as the following table shows.

TABLE 16: TOTAL HOUSING OF EACH COMMUNITY - 1974

Community	Total Dwellings	Mobile Home	Permanent Home		
			Standard	Deteriorating	Delapidated
Cherokee County	67	24	7	14	22
Snowbird	115	12	49	25	29
Big Y	73	5	37	12	19
Painttown	196	47	76	43	30
Soco	246	62	104	23	57
Big Cove	131	18	56	27	30
Birdtown	225	23	130	31	41
3200 Acre Tract	29	8	7	4	10
Cherokee	181	45	72	28	36
Total	1,263	244	538	207	274

Note: Standard: Structures which have no defects or only slight defects which are correctable through regular maintenance.

Deteriorating: Structures having defects which require major repairs to bring up to standard and prevent further deteriorating.

Substandard: Housing that is deteriorating and/or delapidated

There were 207 dwellings in the deteriorating category which makes up 16 percent of all homes and 274 dwellings or 22 percent of delapidated category, so substandard housing is 38 percent of all homes in the area. The distribution of standard and substandard housing in each community is as follows:

TABLE 17: HOUSING DISTRIBUTION ACCORDING TO THE CONDITION - 1974

Community	Total Dwelling	Mobile Home Total	Mobile Home Percent	Standard Home Total	Standard Home Percent	Substandard Total	Substandard Percent
Cherokee County	67	24	35.82	7	10.44	36	53.73
Snowbird	115	12	10.43	49	42.60	54	46.95
Big Y	73	5	6.84	37	50.68	31	42.46
Painttown	196	47	23.97	76	38.77	73	37.24
Soco	246	62	25.20	104	42.27	80	32.52
Birdtown	225	23	10.22	130	57.77	72	32
Big Cove	131	18	13.74	56	42.74	57	43.51
3200 Acre Tract	29	8	27.58	7	24.13	14	28.27
Cherokee	181	45	24.86	72	39.77	64	35.35

These 1,263 dwellings are occupied not only by 5,550 enrolled Cherokee's living in the Eastern Band of Cherokee Indian land, but also by an additional 450 to 500 non-Indians and Indians of other tribes. It means that each house is inhabited by 4.7 people. Considering the average number of occupants for all American household to be 3.2, we can see that Cherokee should have a housing number of 1,875 units. Besides the shortage of the housing, the number of rooms per house in Cherokee is also less than in North Carolina as a whole as well as the United States, as indicated in the following table:

TABLE 18: AVERAGE ROOM OF HOUSING IN EASTERN BAND OF CHEROKEE INDIANS, NORTH CAROLINA AND UNITED STATES IN 1970
(United States Population Census 1970)

Housing with	Cherokee (%)	North Carolina (%)	United States (%)
1 room	1.96	0.6	1.31
2 rooms	3.31	1.6	3.49
3 rooms	19.61	7.8	10.10
4 rooms	34.93	24.6	20.85
5 rooms	20.96	29.5	25.11
6 rooms	8.82	20.2	20.10
7 or more rooms	10.42	15.8	17.65

By the time of the survey, (February 1974), the Qualla Housing Authority has accomplished the following:

- 36 low-cost rental housing units completed
- 277 mutual help homes completed
- 200 mutual help homes under construction

Although the Qualla Housing Authority has built this number of housing units, there are still 481 substandard houses, and this means that about 2,260 persons live in substandard housing.

There are 244 mobile homes in the Eastern Band of Cherokee Indians; the condition of these mobile homes, whether standard or substandard, is not known, If the average of occupants for household is 4.7, it means that about 1,147 persons live in this type of home.

Source:

- Eastern Band of Cherokee Indians: Land Use Analysis and Initial Housing Study, Comprehensive Plan Volume IV, August 1974

- Qualla Housing Authority: Housing Development, mimeograph

SHOPPING AND RECREATION

The Cherokee residents have access to three small shopping centers located within the reservation. Two centers are within the Yellow Hill township, and one is located in the Painttown township. There are numerous craftshops, restaurants, and recreational centers such as, the drama, Unto These Hills; Frontier Land, Santa Land, and the Indian Village catering to the tourist trade.

Many of the people travel to surrounding towns, the nearest one being ten miles away. The town fartherest away lies about 52 miles from Cherokee. These towns are visited with varying degree of frequency.

Each community has a club house or community building where some form of community recreational activity takes place. There are covered-dish suppers, Christmas parties, etc., as well as regular community meetings. The community clubs also sponsor ballteams which participate in reservation competition.

There is a civic center located in Yellow Hill which sponsors day camps for young children out of school for the summer. The center also has a small library. Gospel singing groups and country-western music makers are welcome to use the center. Sports events such as basketball and boxing take place in the center.

There is a recreational park located in the Birdtown community for the use of all communities.

Indian Day, which is the time of the Ramp Festival is a time for all communities to come together for a feast of that delicious, little onion-like ramp and bean bread.

In the autumn, the Fall Festival brings the summer season of harvest and storing-up to a close with a celebration, a homecoming for the off-reservation Cherokee, a time to re-new old friendships and perhaps to make new friends. It is also a time when we share with others a glimpse into our Indian way of life.

CONSUMER INVOLVMENT

The Cherokee Health Board is the principal focal point of consumer involvment. Members carry out their role in the following ways:

1. Involvment in program planning and review (Tribal and Indian Health Service).

2. By maintaining communication with consumers and serving as a sounding board for consumer reaction to services and programs.

3. By establishing priorities for program effort and services.

4. By periodically calling community meetings to discuss special problems and exchange information.

Another consumer organization which is involved in health-related activities is the Cherokee Housing Authority, made up of consumer representatives for each community.

The American Red Cross Blood Program receives donations from persons on the reservation usually exceeding in number of pints donated from other areas in Swain County.

The Ambulance and Emergency Service consists of two ambulances completely equipped for emergency purposes. All members are volunteers, and all have successfully completed the Emergency Medical Technician Course.

Eleven persons have completed the Nurse's Aid Course, sponsored by the Day Care Parent Coordination Department and implemented by USET, Inc., which raises funds for instructors or salary and stipend for participants. Six of these persons are now employed by the tribe and are assigned to work at PHS Indian Hospital, Cherokee, which helps to alleviate the workload due to regular staff shortages.

TRIBAL HEALTH ADVISORY BOARD

The purpose of the board, as stated in the preamble of its constitution, dated October 31, 1974, is:

"To secure to ourselves an organized voice and participation in the provision of health services to members of the Eastern Band of Cherokee Indians;

To secure to ourselves and our descendants the rights and benefits to which we are, or may subsequently become, entitled under the Laws of The United States of America and of the state in which we reside;

To enlighten and give the public a better understanding of matters and problems of health affecting all Indian people;

To enhance and promote the education and understanding of members of the Eastern Band of Cherokee Indians in matters pertaining to their health and services, facilities and opportunities;

And otherwise to promote the common welfare and health of the Cherokee Indians."

The Board, in an advisory capacity, is responsible for monitoring and evaluating designated health service activities; for making recommendations for health priorities, program development and planning; budget recommendations; construction of new health facilities; and for the general coordination of all health programs on the reservation.

The Board, with the approval of the Tribal council, also has the authority to establish scholarship funds in the field of health care and medicine and to determine the recipients of those funds.

The Board is composed of four Tribal council members, four persons from the Cherokee Health Delivery System, and one member from each of the seven communities.

HOSPITALIZATION

Public Health Service operates a 26-bed hospital which includes 16 general medical beds, six for pediatrics and four for obstetrics, to serve a group of 5,550 persons in six scattered communities, in 57,000 mountainous acres.

The hospital was built in 1936. It is a one-story structure of native stone, in need of repairs in many areas. The staff works continually and with dedication to bring the hospital up to accreditation, but the structure itself cannot qualify. There is need for much more storage space for some items such as wheel-chairs, stretchers, and commode-chairs; storage space is non-existant. Sections of hallways are used as storage areas creating serious fire hazards. The distance between obstetrical wards, delivery room and nusery are much too great, allowing too much chance of cross-contamination. Hazards of infection are ever present in such a set-up. Cherokee has been most fortunate in not having had a greater incidence of cross-contamination, owning largely to a continuous awareness of the danger and resulting extreme care on the part of all departments.

There is also one outpatient clinic located in Snowbird (Cherokee people) located nearly 50 miles from Cherokee in Graham County, where services are available twice a month. The Snowbird Clinic is staffed by health professionals from Cherokee. The Tribe is at present constructing a building at Snowbird for clinic use; the services are presently located in the community center.

In case of necessity, patients may be referred by the staff of Cherokee Hospital to any of the following hospitals, on a contract basis:

Swain County Hospital in Bryson City, N.C.
Memorial Mission Hospital in Asheville, N.C.
Haywood County Hospital in Waynesville, N.C.

Physicians in the following communities also see individual patients under a contractual agreement:

Bryson City-------- one
Sylva-------------- one
Robbinsville------- one
Waynesville-------- one
Asheville Orthopedic Associates, PA
(Staff of four)

Ten disease categories comprise 69% of the total workload of 17 diseases.
In-patient days for contract health services - total - 1,647
Direct patient care - total - 5,178
Outpatient visits for contract health care - total - 2,976
Outpatient direct patient care - total - 38,569

Representatives of the 12 departments in the hospital have agreed that top priorities are according to the following:

1. Endocrine, metabolic, blood disorders
2. Misuse of alcohol and/or other drugs
3. Respiratory tract
4. Gastro-intestinal disease
5. Obsterical-Intestinal
6. Circulatory system disease
7. Neuro-psychiatric disease
8. Trauma: accident, poison. violence
9. Genito-urinary tract
10. Infective and parasitic disease

This priority listing is not based upon number of patient visits but rather upon evident health needs, severity of the illness and effect of the illness upon the patient's productivity, family responsibilities and general health.

The listing was made by representatives of the medical staff, nursing staff, medical records, laboratory, dental clinic, pharmacy, administration, Office of Enviromental Health, Snowbird Clinic, psychological services, health education and maintenance departments.

Workload by disease category

Respiratory disease	13%
Circulatory disease	9%
Endocrine, metabolic and blood disorders	9%
Obsterical-gynocological	8%
Trauma, accident, poison and violence	8%
Neuropsychiatric disease	7%
Gastro-intestinal	5%
Muscular-skeletal	4%
Skin diseases	3%
Genito-urinary tract	3%

These ten disease categories comprise 69 percent of the total for all 17 categories which include infective and parasitic disease, ear disease, cogential, prenatal and birth defects, neoplasm, central nervous system disorders, eye diseases, and "all other". These data can be examined on Table 19, 20 also on Graph 3, 4, and 5.

TABLE 19

LOCATION Cherokee — PERCENTAGE OF EFFORT (WORKLOAD) BY DISEASE CATAGORY — PERIOD OF TIME 1975

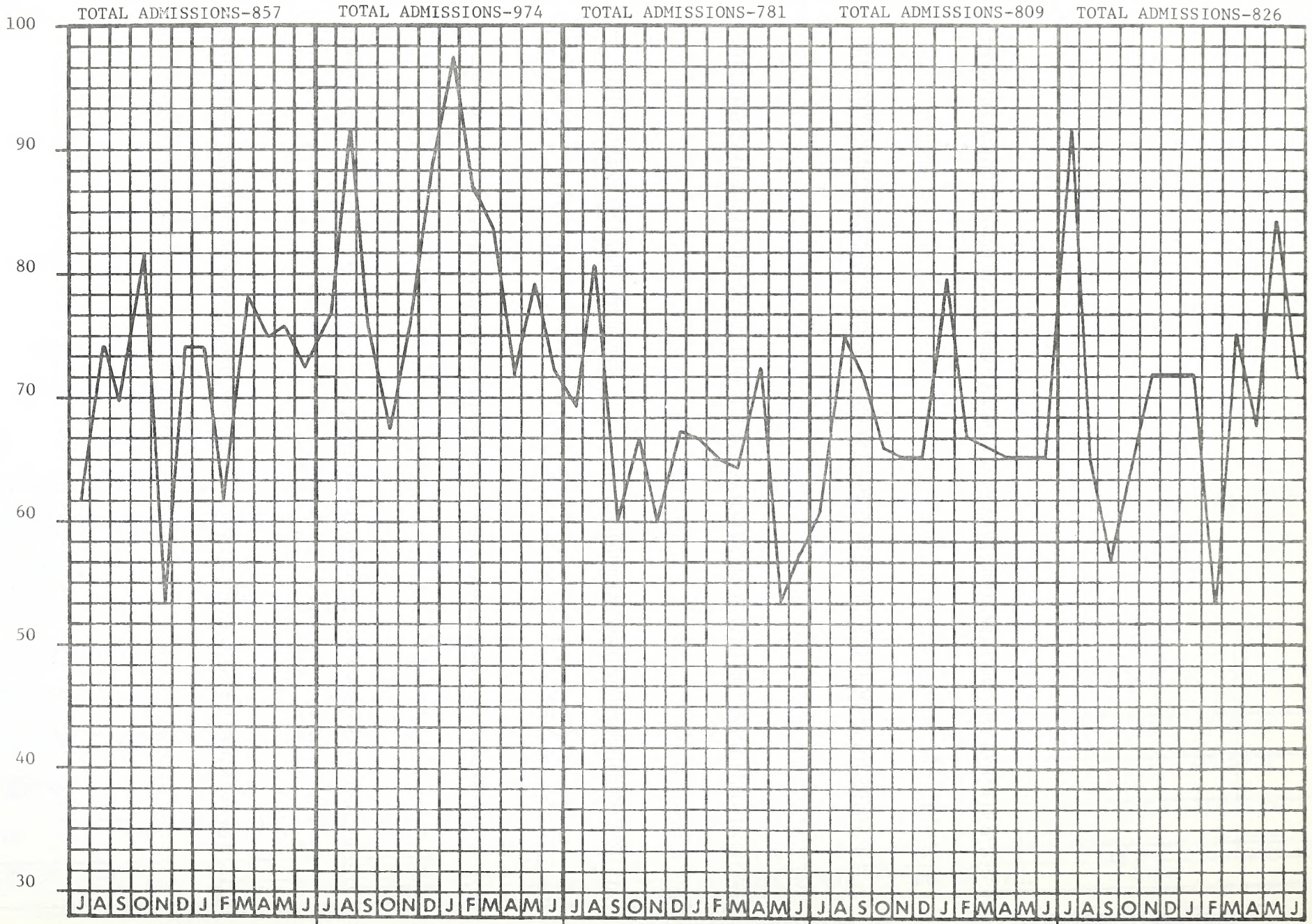
DISEASE CATAGORY	CONTRACT HEALTH SERVICES				DIRECT PATIENT CARE				COMBINED WORKLOAD*		
	I.P.D.'S	%	O.P.V.'S	%	I.P.D.'S	%	O.P.V.'S	%	TOTAL WORK UNITS	%	PRIORITY
INFECTIVE & PARASITIC DISEASE	12	1	92	3	125	2	1227	3	401	3	11
NEOPLASM	118	7	18	1	84	2	71	0	220	2	14
ENDOCRINE,METABOLIC,BLOOD DISORDS	102	6	184	6	651	13	2748	7	1339	9	3
NEUROPSYCHIATRIC DISEASE	9	1	39	1	753	15	1086	3	987	7	6
CENTRAL NERVOUS SYSTEM DISORDERS	66	4	26	1	19	0	538	1	198	1	15
EYE DISEASE	0	0	65	2	0	0	694	2	152	1	16
EAR DISEASE	20	1	73	3	21	0	1599	4	375	3	12
CIRCULATORY SYSTEM DISEASE	94	6	115	4	638	12	3133	8	1382	9	2
RESPIRATORY DISEASE	39	2	781	26	409	8	6929	18	1990	13	1
GASTRO-INTESTINAL DISEASE	215	13	146	5	197	4	1280	3	697	5	7
GENITO-URINARY TRACT DISEASE	40	2	126	4	194	4	843	2	428	3	10
OBSTETRICAL-GYNOCOLOGICAL	248	15	301	10	559	11	1998	5	1267	8	4
SKIN DISEASE	4	0	150	5	97	2	1888	5	509	3	9
MUSCULOSKELETAL DISEASE	87	5	376	13	51	1	1594	4	532	4	8
CONGENITAL PERINATAL & BIRTH	59	4	21	1	175	3	44	0	247	2	13
TRAUMA(Accid.,Poison,Violence)	421	26	129	4	261	5	2720	7	1252	8	5
ALL OTHER	113	7	342	11	944	18	9997	26	3125	21	N.A.
O.P.V.'S = FIRST VISITS			1981				17186	45	*I.P.D.'S + O.P.V.'S / 5 = Total Workload Units		
O.P.V.'S = REVISITS			995				21383	55			
TOTAL	1647	100	2976	100	5178	100	38569	100	15,120	100	

TABLE 20

LOCATION Cherokee — OUTPATIENT WORKLOAD ANALYSIS..DISEASE/LOCATION — PERIOD OF TIME 1975

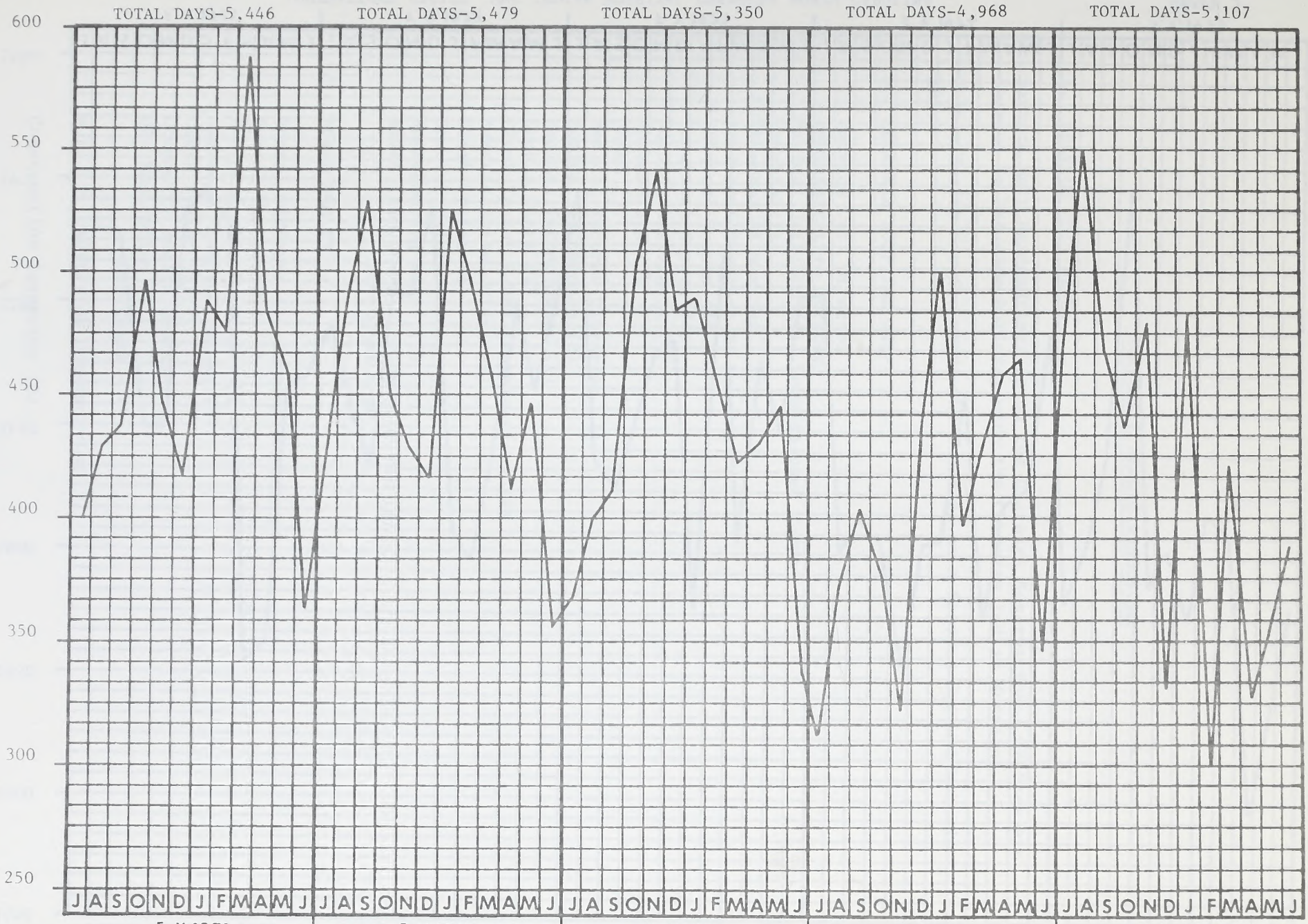
DIRECT PATIENT CARE

CLINIC / DISEASE CATAGORY	HOSPITAL O.P.V.'S	%	SNOWBIRD O.P.V.'S	%	CHEROKEE SCHOOL O.P.V.'S	%	BRYSON CITY O.P.V.'S	%	TOTAL O.P.V.'S	%
INFECTIVE & PARASITIC DISEASE	1205	3	12	1	1	0	9	7	1227	3
NEOPLASM	70	0	1	0					71	0
ENDOCRINE,METABOLIC,BLOOD DISORDS	2525	7	216	24			7	6	2748	7
NEUROPSYCHIATRIC DISEASE	1058	3	27	3			1	1	1086	3
CENTRAL NERVOUS SYSTEM DISORDERS	523	1	13	1			2	2	538	1
EYE DISEASE	683	2	11	1					694	2
EAR DISEASE	1567	4	27	3			5	4	1599	4
CIRCULATORY SYSTEM DISEASE	3117	8	189	21			7	6	3133	8
RESPIRATORY DISEASE	6784	18	123	14			22	17	6929	18
GASTRO-INTESTINAL DISEASE	1251	3	24	3			5	4	1280	3
GENITO-URINARY TRACT DISEASE	828	2	14	2			1	1	843	2
OBSTETRICAL-GYNOCOLOGAL	1974	5	20	2			4	3	1998	5
SKIN DISEASE	1867	5	18	2			3	2	1888	5
MUSCULOSKELETAL DISEASE	1555	4	29	3	2	0	8	6	1594	4
CONGENITAL DISORDERS	43	0	1	0					44	0
TRAUMA(Accid.,Poison,Violence)	2692	7	23	3			5	4	2720	7
ALL OTHER	9601	25	159	18	190	100	47	37	9997	26
FIRST VISITS	16809	45	310	34	16	8	51	40	17186	45
REVISITS	20534	55	597	66	177	92	75	60	21383	55
TOTAL	37343	100	907	100	193	100	126	100	38569	100



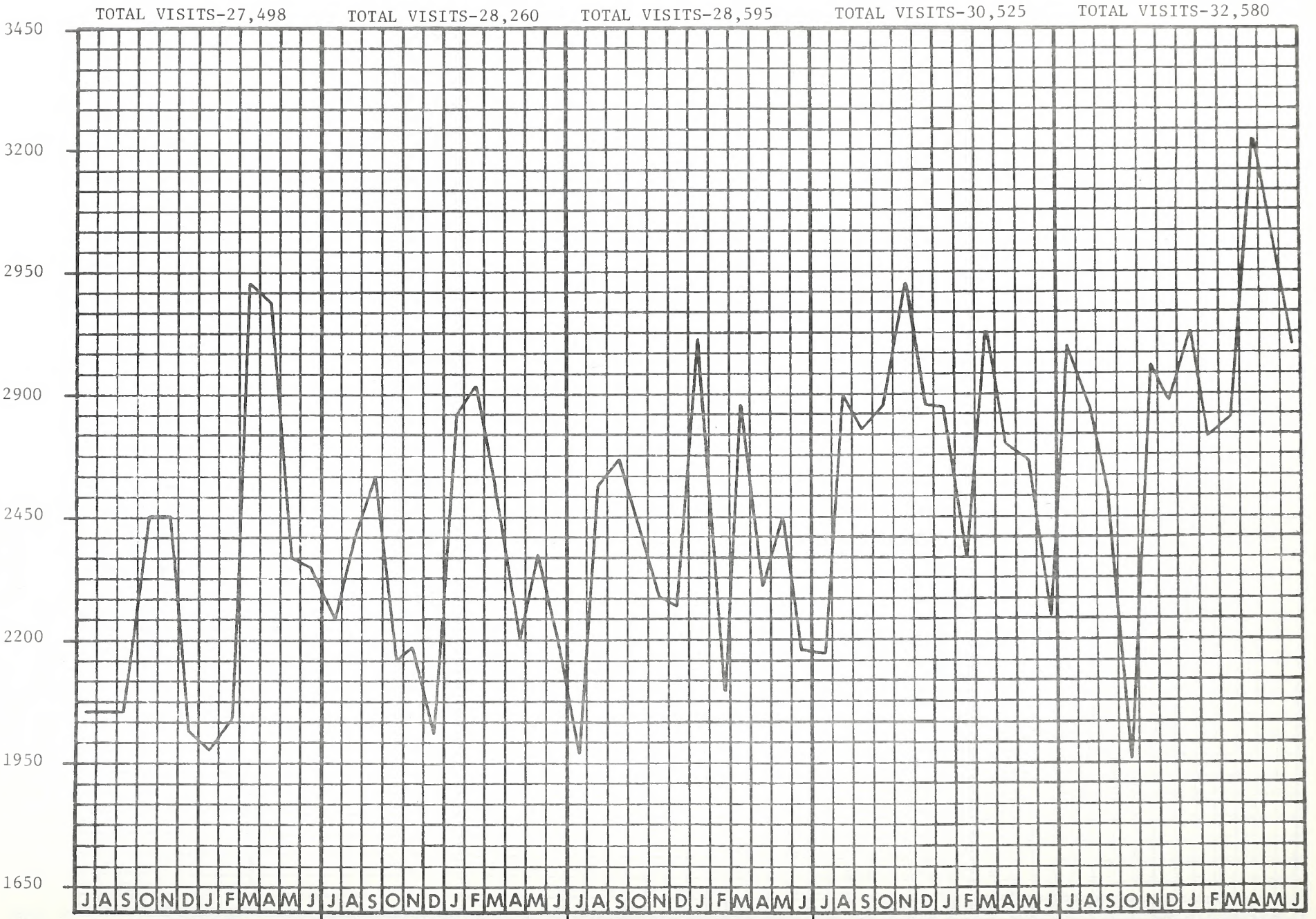
ADMISSIONS..PHS INDIAN HOSPITAL CHEROKEE NORTH CAROLINA

GRAPH 3



INPATIENT DAYS..PHS INDIAN HOSPITAL CHEROKEE NORTH CAROLINA

GRAPH 4



OUTPATIENT VISITS..PHS INDIAN HOSPITAL CHEROKEE NORTH CAROLINA

GRAPH 5

AVAILABLE HEALTH RESOURCES

I. SERVICE UNIT WIDE:

Service Unit Headquarters is on the Cherokee Reservation. Offices are located in the same building with the Cherokee Indian Hospital.

Indian Health Service staff who function on a Service Unit wide basis are:

A. CHEROKEE HOSPITAL STAFF

Service Unit Director
Administrative Officer
Medical Officers (4) Commissioned Corps
Psychiatrist
Director of Nursing
Assistant Director of Nursing
Clinical Nurses (8)
Practical Nurses (4)
Nursing Assistants (3)
Pharmacists (3)
Cooks (3)
Medical Records Librarian (1)
Medical Technician (2)
Medical Technologist (1)
Supply Clerk (1)
Clerk Typist & PBX (Combination) (1)
Administrative Clerk (1)
Clerk Typist (1)
General Maintenanceman (1)
Housekeeping staff (2)
Aides (temporary) 1 plus 6 tribal (7)
Sub-total - 48

B. FIELD HEALTH

Dental Officers (2) Commissioned Corps
Dental Technicians (2)
Public Health Nursing - RN (1)
Licensed Practical Nurse (1)
Clerk Typist (1)
Community Health Educator (1)
OEH Sanitarian (1)
Sub-total - (9)

C. P.L. 121 SANITATION CONSTRUCTION

Construction Inspector (2)

Sanitarian Technician (1)
Supervisory Construction Inspector (1)
Clerk Typist (1)
Sub-total (5)

Total - 62 consisting of 10 Commissioned Corps
52 staff members

Other resources that participate in the Health Care Program on a Service Unit wide basis are:

1. Lion's Club - Asheville
2. Vocation Rehabilitation
3. WNC Lung Association - Asheville
4. American Cancer Society - Asheville
5. The Health Education Commission of Western North Carolina - Asheville
6. North Carolina Department of Human Resources - Division of Health Services Film Library - Raleigh
7. Department of Health - Bryson City
8. State Health Service for Blind - Asheville
9. Alcoholism Rehabilitation Center - Black Mountain
10. Detoxification Unit - Western North Carolina
11. T.B. Clinic - County
12. Western Carolina Hospital for TB - Asheville
13. Social Service County & BIA - Raleigh
14. Food Stamp Program - Raleigh
15. School for Blind - Western Region, North Carolina

II. RESOURCES FOR THE TRIBE:

1. Cherokee Indian Hospital
2. Snowbird Clinic
3. Tribal Health Board
4. Tribal Health Coordinator
5. Community Health Representative
6. Otitis Media
7. Rescue Squad
8. Mental Health & Alcoholism Program
9. Social Service
10. Commodity Food Program
11. Food Stamps
12. Housing Authority
13. Social Services - BIA

Chapter II : PROGRAM DESCRIPTION

Administration

Direct Patient Care :

- Medical Care
- Nursing
- Laboratory
- Medical Records
- Psychological Services
- Maintenance

Field Health :

- Public Health Nursing
- Dental Clinic
- Health Education
- Pharmacy
- Environmental Health
- Snowbird Clinic

Tribal Contract Health Care :

- Alcohol and Mental Health Program
- Otitis Media Program

ADMINISTRATION

GOAL:

To bring about improved patient care through better administrative service related directly to patients; improved relationships and services to beneficiaries in general; more effective management and administrative service to the Service Unit staff; and increased personnel utilization, productivity and morale. To bring about a more effective personnel and office service program. To bring about improved patient care through better management of property and supply services to users directly. To increase personnel utilization and to improve management techniques in compliance to the service unit disciplines.

BACKGROUND:

This program is to provide information to those concerned with operational plans of the Cherokee Hospital Administrative Branch for Fiscal Years 1976 and 1977. Included are problems, objectives, and plans of action.

In keeping with management by objective concept, this planning is intended to achieve the following:

(a) Improved patient care, safety, convenience and general well-being through a more effective management and administrative service.

(b) Allocation of efforts to the most needed project through a system of priorities.

(c) Provision of continuity in spite of personnel changes or other program changes.

(d) Increase coordination among related disciplines and offices.

(e) Improve personnel development and evaluation techniques.

This introduction is designed to serve as a summary of plans. The details of such plan of action, target dates, phase, etc., are included on the following sheets.

We are individually and collectively committed to these plans which were developed by individual efforts initially.

MEDICAL CARE

GOAL:

To provide comprehensive medical and health care services to all members of the Eastern Band of Cherokee Indians, their dependents, and other eligible individuals. This goal should be accomplished by utilizing all available resources in order to raise the health standards of the Cherokee Indian to the highest possible level.

PROFILE:

The present population of the Eastern Band of Cherokee Indians living on the reservation is considered to be 5,550. The reservation covers 57,000 acres and is located mainly in the counties of Swain and Jackson, with smaller sub-divisions in Graham and Cherokee counties. In addition, it is estimated that approximately 1,500 people reside in off reservation areas. The average age of the population is estimated to be 35 years old, with about 40% being male and 60% being female. Most of these people return to the reservation for medical care as well as for other health care services.

The Public Health Service is the primary source of comprehensive health care for the Eastern Band of Cherokees. The Public Health Service Indian Hospital, located at Cherokee, North Carolina, is a 26-bed general hospital which was built in 1936. The bed capacity is divided into 16 general medical beds, including one coronary care unit bed, 6 pediatric beds, and 4 obstetrical beds. Also included in the hospital is a newly remodeled 3-bed emergency room and a recently constructed bed nursery.

Adjacent to, and connecting with the PHS Hospital is an outpatient clinic, the construction of which was completed in October of 1974. The outpatient clinic consists of 6 medical examining rooms, a Nurses Station, a comfortable waiting room, a 5-chair Dental Clinic, the Pharmacy, and all Laboratory and X-ray facilities. In addition the outpatient clinic houses the Administrative and Public Health Nursing departments.

Direct Patient Care:

The Cherokee Service Unit provides direct patient care through the U.S. P.H.S. Hospital and Outpatient Clinic at Cherokee, North Carolina and the Snowbird Clinic at Robbinsville, North Carolina.

1. U.S.P.H.S. Hospital and Outpatient Clinic

   This facility is open 24 hours a day, 7 days a week, with the outpatient clinic open from 9:00 a.m. - 5:00 p.m. - 5 days a week.

Patient care facilities are available at nights and on week-ends for any and all emergencies with an IHS physician on call at all times. At the present time, the Cherokee Service Unit has 5 full time physicians which includes 3 general medical officers, 1 pediatrician, and 1 psychiatrist.

The PHS Hospital at Cherokee, N. C. is now equipped to perform all routine and many specialized laboratory and x-ray procedures. The x-ray department is presently being equipped to perform fluoroscopic procedures such as upper GI series and barium enemas, etc. Certain more sophisticated procedures such as endocrine function studies, serum electrophorsis studies, brain and liver scans, EEG's, etc. are performed by private laboratory and x-ray facilities under contract.

The outpatient clinic at Cherokee, N. C. sees on the average approximately 100 patients per day during the week days. Outpatient visits for FY-1975 numbered 38,569. Certain specialty clinics are provided in the outpatient clinic on a weekly basis. Weekly clinics include preventive medicine clinic, prenatal clinic, well-baby clinic, post partum clinic, and diabetic clinic. The weekly clinics are usually held in the morning from 9:00 a.m. - 11:00 a.m. In addition: Eye Clinic, ENT Clinic, Internal Medicine Clinic, and Orthopedic Clinic are held monthly with a specialist from nearby cities in attendance. A Chest Clinic is also held twice a year.

2. Snowbird Clinic

The Snowbird Clinic is held twice a month to provide outpatient care to a smaller population of Cherokee located on a segment of the reservation in and around Robbinsville, N.C., approximately 50 miles from Cherokee, N.C, Presently under construction is a new clinic facility which will provide more expanded outpatient services. The new clinic will be open at least once and perhaps twice a week with a Community Health Medic (Physician's Assistant) in attendance. An IHS physician will be available for problem cases.

Statistical and Graphic Data

Examination of APC printouts and statistical tables reveals that the ten most common reasons for outpatient visits ranked by workload are: (1) respiratory disease; (2) circulatory system disease; (3) endorcine, metabolic, blood disorders; (4) obstetrical and gynecological; (5) trauma; (6) neuropyschiatric disease; (7) gastro-intestinal disease; (8) musculo-skeletal disease; (9) skin disease; and (10) genito-urinary tract disease (See Table 18). Because respiratory disease comprises such things as the common cold and sore throats, endocrine, metabolic, and blood disorders were felt to represent the highest priority disease process among the Eastern Band of Cherokees on the basis of workload, morbidity, and mortality.

Examination of other statistical information reveals that the total number of outpatient clinic visits for FY-1975 was 38,569 which represents a 6% increase in visits from FY 1974 (See Table 19 and Graph 5). This is felt to reflect the opening of the new outpatient facility at Cherokee, N.C. as well as the expansion of clinic facilities.

During FY 1975, hospital admissions were increased by 2% over FY 1974 while total impatient days were up 3% (See Graph 3 and Graph 4). With continued upgrading of hospital and clinic services and the addition of more modern equipment, this particular relationship of hospital admissions to total inpatient days will change. Indeed, for the first quarter of FY 1976, hospital admissions continued to increase, while total number of inpatient days decreased. These figures reflect dramatically the efforts to provide more and better total health care.

Contract Medical Care

Certain procedures which are not presently available at the Cherokee Service Unit are provided on a contract basis through specialists at nearby hospitals and medical centers. General surgery, cardiovascular surgery, intensive care, neurological, genitourinary, eye, and ENT procedures are provided through contract medical care funds with certain referrals occasionally made to several of the larger PHS Hospitals.

NURSING

GOAL:

To provide quality nursing care to inpatients and outpatients, both preventive and therapeutic, and to make appropriate use of available resources.

BACKGROUND:

Nursing personnel are responsible for nursing care on all inpatients in this twenty-six bed hospital. This includes general medical, post-op surgical, pediatric, obstetrical unit, one-bed coronary care unit, emergency room, and all outpatient clinics, such as preventive medicine, diabetic, well-baby, prenatal, and general clinic.

Programs contributing to achievement of goals:

A. Monthly meetings of nursing personnel
   1. To assure appropriate use of personnel.
   2. To establish criteria, standards, and norms by which nursing service can be evaluated and upgrade.
   3. Through periodic nursing audits, establishes peer review of charts and records and enables us to correct deficiencies.
   4. One in-service meeting held monthly. Some subjects covered:
      a. How to deal with the emotionally disturbed or alcoholic patient in the general hospital setting.
      b. Problem oriented record keeping.
      c. Emergency procedures and plan of action as they pertain to our hospital.
   5. Staff attends workshops and seminars when staffing permits to enable them to keep abreast of new trends in nursing and gives in-service conferences on subjects covered on return to hospital.
   6. Nursing personnel endeavor to work as a team with medical staff, pharmacy staff, medical records department, laborotory, and administration with the common objective of improving quality of health care.

B. Program Subdivisions:
   There is a need for a closer working relationship with the people who work under these programs.
   1. Community Health Representatives
   2. Field Health
   3. Office of Environmental Health
   4. Schools
   5. Mental Health
   6. Otitis Media

Some problems encountered are:

Shortage of Nursing staff - (8 staff nurses, 5 physicians)

1. R.N.'s are putting in much overtime.
2. Unable to fill vacancies readily.
3. Unable to adequately staff clinic.
4. Inadequate work and storage areas in hospital; the functional design is extremely poor.
5. Absolutely no conveniences for nursing personnel, such as bathrooms, lockers, etc.
6. Morale of staff low, and many are often times to point of exhaustion resulting in frequent use of sick leave.
7. No Dietitian - Dietary problems take nursing supervisor away from nursing duties frequently, and actual time that can be allotted to dietary department is not adequate.

LABORATORY

GOAL

The function of the laboratory and x-ray Department is to provide continously high quality workmanship for clinical procedures and x-ray, necessary for the physician to make an accurate diagnosis of the patient's disease process and enable him to effectively manage the patient's problem.

BACKGROUND

Laboratory and x-ray services at the Cherokee Service Unit have made a steady improvement in both the physical plan and the quality of performance of the test procedures. From a beginning of 35 square feet, with untrained personnel performing tests, the physical plant has expanded to over 400 square feet. Equipment has steadily improved from a low of one small centrifuge, one microscope, one hot plate, and one photometer, to a battery of specialized and highly sophiscated laboratory instruments.

In the ares of personnel, over the years, laboratory services have improved from the nurse dip stick era, to the present staff trained specifically in the field of Medical Technology with the academic background and work experience to produce high quality workmanship of a diversified nature. The number of procedures completed annually have risen to more than 34,000.

Services in the X-ray Department have also improved dramatically. From untrained personnel snapping x-rays without regard to radiation hazards, the Service Unit has progressed to a well-equipped and properly protected x-ray room with techicians who have had proper basic instructions in the performance of their duties, including proper precautions against radiation hazards, or over-exposure of patient or personnel. There are over 5,000 exposures done annually, as well as 500 EKG's.

MEDICAL RECORDS

GOAL:

To provide a coordinated Health Records system to facilitate the recording of all preventive, curative, and rehabilitative procedures by USPHS medical and dental staff, consultants, and paramedical personnel in a unit record. This unit record is maintained on all patients, either inpatient or outpatient, served by the Cherokee Service Unit. The recordings are to be complete, accurate, and current, in order to provide continuity of patient care.

BACKGROUND:

There are currently 8,600 charts maintained, of which approximately 7,500 are active. The outpatient workload averages 33,000 visits per year.

Prior to July 1974, Health Records was staffed by two people, the Health Record Technician and the receptionist-clerk. Health Record duties, such as Third Party Liability cases, were being performed by the Administrative clerical staff. There was a tremendous backlog of insurance forms and other types of correspondence which, if and when it was done, was very late. Transcription was done on an overtime basis by the Health Record Technician. The filing of late lab work was also backlogged. The Department was located in a very small room which also was used as a small waiting room for patients, laboratory, x-ray, and file room for health records. The Health Record personnel were also responsible for answering all incoming telephone calls for the hospital.

Since July 1974, Health Records has been staffed by three personnel, the Health Record Administrator, Health Record Technician and the receptionist-clerk. In September 1974, the new outpatient clinic was opened, at which time the Department was moved into a separate area consisting of two rooms - one small room for the receptionist - clerk, and one larger room for the Health Record Administrator and the Health Record Technician, and the files. The Department is no longer responsible for answering incoming hospital calls. There has been a definite separation and consideration of Health Records as a separate department. Health Records is now responsible for completion of the Third Party forms and submitting this information to the Regional Attorney. There are now two qualified people to do transcription so this no longer has to be performed on an overtime basis.

In September 1975, an appointment system was instituted and the receptionist-clerk is now responsible for making and recording appointments, filing appointment slips, in addition to her other duties. Health Records still has a problem with the filing of late lab slips for this reason, and another person is badly needed to help in this area. In order for the

receptionist-clerk to get her filing done on a timely basis, either the Health Record Administrator or the Health Record Technician must help her. Our lab work has also increased tremendously since the move to the new clinic from 50 per month to 275 per month.

Plans are currently underway for the institution of the color code filing system in Health Records. This will call for a concentrated effort in thinning charts, breaking charts down into two or more parts, removing inactive charts from the files, and replacing the existing active files with the new color coded files.

At present there are no facilities for a storage area for Health Records which are inactive, death charts, or partial charts. At present these are kept in the Supply Officer's storage area, which is locked, but still inadequate. A special storage area should be designated for Health Records use only.

New dictating equipment has been ordered and will be installed shortly. There will be three phone hookups to the new recording machine which will be in Health Records. It is planned for one of the phones to be placed in the x-ray reading room and future plans are for the radiologist to come in, do fluorscopies and read films, then dictate. At the present time, it is uncertain as to whether the radiologist will be responsible for having these reports transcribed or whether the hospital will be responsible for transcribing these reports.

PSYCHOLOGICAL SERVICES
MENTAL HEALTH, ALCOHOLISM AND DRUG ABUSE PROGRAM

GOAL:

To overcome the anxiety provoked in others by those suffering from emotional problems in order to carry out effective care. To help the community to recognize that mind and body are not separate, but together. To improve the health status of the Eastern Cherokee Indians by providing a good health service for people with emotional problems.

BACKGROUND:

The Cherokee Reservation, like most all the communities in the United States today has problems with the misuse of alcohol and drugs. Also, it appears that these problems are magnified by the communities being a racial minority group.

The Cherokee Community has an Alcohol and Drug Abuse Program consisting of a Director and four para-professional workers. There is a psychiatrist at the Cherokee Indian Hospital. The program is under Tribal management. The psychiatrist is with Indian Health Service.

MAINTENANCE

GOAL:

To assist the departments within the hospital facility by keeping a clean, safe working environment.

BACKGROUND:

The maintenance department includes housekeeping, safety, grounds, quarters, and hospital. The program plans of the various departments were developed to facilitate the accreditation of the hospital through improvement of the environment. Although not directly related to other program plan objectives, this plan would have great impact on other department objectives by an improved environment within and around the facility; the ultimate being to raise the elevation of health of the Cherokee Indian to the highest possible level with personnel and funds available.

PUBLIC HEALTH NURSING

GOAL

To provide a program of complete services in the areas that we have chosen to emphasize, based on established priorities.

BACKGROUND

Public Health Nursing serves a population of 5,500 persons covering an estimated populated area of 20,000 acres. There are approximately 1,400 homes with approximately 1,500 - 1,600 families scattered over this area.

At present, the staff is involved in all Specialty Clinics: Eye, ENT, Orthopedic, Chest, Well-Baby, and the Snowbird Clinic (60 miles away) two days a month. This includes scheduling, conducting, and follow-up. They also do new prenatal counseling.

The program does all school re-screening in vision and physicals and follow-up, on the Twelfth, Eighth, Third, and Pre-Schoolers, plus any additional sports physicals that are needed. Immunizations in the Kindergarten groups are also done by this program. Also, they do the health certificate screening and work-up for school cafertia employees, kindergarten teachers, and day care center personnel.

Public Health Nursing does the screening and work-up for the school bus driver physicals each fall.

They follow-up contacts in tuberculosis and V. D. and all other reported communicable diseases.

They contact (home visit) women with abnormal Pap tests, and pre-mature or high risk babies.

Each fall, a new group of Junior Nursing Students from Western Carolina University in Cullowhee are assigned to the Public Health Nursing section of ther service unit for a period of two years to obtain their field health experiences. The public health nurse and licensed practical nurse select families, (3/student nurses contact the families) acquaint the student with the family and follow-up on anything that is found that the student cannot do.

This is a fraction of what Public Health Nursing does, and what they are responsible for.

For this program there is one public health nurse, one licensed practical nurse, and one clerk.

DENTAL CLINIC

I. Priorities:

Emergency Care: Infection and traumatic injuries have priority over all other treatment.

Routine Care: Children have priority over adults for routine dental treatment and contract expenditures.

II. Type of Services provided:

A. Comprehensive Child Care

Pulpotomies, stainless steel crowns, space maintainers, anterior composite and posterior amalgam restorations, extractions, limited orthodontics, proplylatic tooth cleaning; topical fluorides and oral hygiene instructions.

B. Dental Services for adults.

Anterior composit and posterior amalgam restorations; endodonics on anterior teeth. Crown and bridge with patient paying the dental laboratory fees. Prosthetics (dentures and partial dentures) with patient paying laboratoey fees. Scale polish and oral hygiene instructions, including diet counseling. All phases of oral surgery is complex and necessitates the use of a specialist the patient is referred to Memorial Mission Hospital and services are paid for via contract funds.

III. Hospital Dental Care:

The Dental staff works closely with medical team to provide care in the treatment of patients with special medical problems. These areas of special concern include, diabetics, heart disease, mental retardation, epilspsy, and prenatal care.

IV. Contract Care

A. Contract monies will be spent for pedodontics and oral surgery.

B. Contract funds will not be spent for routine adult care except when USET makes special funds available, or at the end of the Fiscal Year when some contract monies may be unused.

DENTAL PROGRAM PRIORITIES

I. To achieve proper functioning of the community water flouridators.

II. Secure funds to equip the Snowbird Dental Clinic.

III. The achievement of greater dental awareness through better dental health education.

IV. Completion of the needed staffing of the dental clinic.

V. Establishment of a dental repair service for the USET area.

HEALTH EDUCATION

GOAL:

To improve the health status of Cherokee Health care consumers through educational effort that furthers the development of good individual, family and group health practices and enhances the benefits derived from other health programs and services.

BACKGROUND:

An accepted and long-standing definition of health education is credited to Wood, who stated that health education is "the sum of experiences which favorably influence habits, attitudes, and knowledge relating to individual, community and racial health". Therefore, the main purpose of the Community Health Education Program is to help the particular individuals or groups to acquire a better educational approach about health and to give them the opportunity to change and improve their health practices.

Cherokee PHS Indian Hospital added a Health Education Department in November 1965. It was planned that they would try to improve people's health practices by using educational methods and techniques based on research findings from the basic behavioral sciences, so that the people can recognize and understand the problem and may participate in making a decision about their health in a responsible manner.

Representatives of the twelve departments in the hospital have agreed that the top ten disease category priorities are as follows:

1. Endocrine, metabolic, blood disorders
2. Misuse of alcohol and/or other drugs
3. Respiratory tract infection
4. Gastro-intestinal disease
5. Obstetrical-Gynological
6. Circulatory System Disease
7. Neuropsychiatric Disease
8. Trauma
9. Genito-Urinary Tract
10. Infective and Parasitic Disease

Efforts to reduce or control such problems are negated or attenuated by poor individual, family and group health practices on the part of the health service consumers. Moreover, preventive health concepts are generally either not well understood or are rejected.

Organized intensive educational effort is urgently needed to be directed toward developing understanding and acceptance of the concepts which underlie recommended personal, family and group health practices, by all disciplines of the health providers.

CURRENT SITUATION:

Presently, there is only one person in the Community Health Education Department. There is a need for additional personnel. In addition to health education activities per se. the Community Health Educator serves as Service Unit Program Planning Coordinator, and as a counselor, has guided two MPH students of the University of Tennessee through their field training for the Fall Quarter 1975.

PHARMACY

GOAL:

To work in cooperation with the health delivery team to provide the best possible care for members of the Eastern Band of Cherokee Indians.

BACKGROUND:

The Cherokee Pharmacy is located in the new clinic which is attached to the hospital. The hospital has twenty-four (24) beds and three (3) bassinets. The hospital-clinic pharmacy serves a population of 8,381. During F.Y. 1975, there were a total of 38,000 outpatient visits, and an average daily patient load of seventeen.

The pharmacy is staffed by three pharmacists. The pharmacy offers complete services for these 8,381 Indian recipients. The pharmacy hours are from 8:00 a.m. until clinic is over each weekday. The hospital and emergency rooms are stocked by the pharmacy for after hours care and emergency care.

ENVIRONMENTAL HEALTH

GOAL:

The goal of the Cherokee Service Unit, Office of Environmental Health is to initiate a program which will help the Indian people to become self-sufficient. The objectives of these programs are to help the Indian people understand the environmental health problems and how to prevent them. The Office of Environmental Health also intends to broaden its program in home safety. The Office of Environmental Health hopes to accomplish these goals through education of the Indian people and construction of sanitation facilities.

BACKGROUND:

The Cherokee Service Unit is located in the mountains of Western North Carolina. There are 57,000 acres spread over five counties with the largest concentration of Indian homes located in Swain and Jackson Counties. There are two major water systems serving 320 homes. There is one waste treatment plant serving 218 homes. There are 473 individual water systems (springs, reservoirs, and wells) serving 1,073 homes. There are 1,232 septic tanks serving 1,232 homes. There are 35 restaurants, 40 motels, 6 trailer parks and 24 campgrounds. This survey was conducted in the fall of 1975, and completed on December 8, 1975 by the Office of Environmental Health, Cherokee, North Carolina.

SNOWBIRD CLINIC
COMMUNITY HEALTH MEDIC PROGRAM

GOAL:

To improve the health status of the Eastern Band of Cherokee Indians, especially those who live in Snowbird Community by giving a convenient health service to them, including curative, preventive, and quality health service.

BACKGROUND:

A community health medic (CHM) is a type of physician's assistant (p.a.) trained and authorized to provide primary health care under the supervision of a physician. CHM's receive training in addition to the usual p.a. training to enable them to teach Indian patient's improved health methods, and to work with community groups in planning for their health care. CHM's are trained to work primarily in outpatient departments and field clinics treating and triaging ambulatory patients. While CHM's receive exposure to inpatients during their training, and to serious illness, it is expected that physicians will provide care for seriously ill and hospitalized patients.

The CHM Training Program was established in 1971, to train Indian people who already had established themselves in health career to a higher level of medical competence as a general practice physician's assistant. Because of limitations on clinical training space, it was necessary to establish two training sites (Gallup and Phoenix) in order to meet the projected needs of IHS facilities for CHM's. By September, 1975, over 60 CHM' will have been graduated from the two programs, with another 47 students in training. All but a few graduates are presently working in IHS facilities. Of those who are not, two are pursuing pre-medical studies, and several have gone into administration. The training programs at Gallup and Phoenix are similar, consisting of one year at the training base,followed by a second year of supervised clinical experience under an IHS physician-preceptor (the "Preceptorship"). Applicants to the program must have at least three years of education and experience in a health field such as nursing, corpsmen, medical technology, etc. The most successful candidates also have one or more years of college education. The students, as well as the training program, are expected to qualify for national certification in the p.a. occupation. In 1973, both CHM programs received approval from the A.M.A., the Civil Service Commission, the Veteran's Administration, and the Universities of New Mexico and Central Arizona College (Gallup and Phoenix, respectively) for transferable college credits. Consequently, during the two years of training, CHM students earn 72 hours of college credits. These may be applied toward the Bachelor's or Associate Degrees, as appropriate for the individual. All CHM's who have taken The National Board Examination for p.a.'s have not passed it. Consequently, CHM's have the ability to work not only in the Federal System, but for private

physicians as well.

Increasing numbers of CHM's are being attracted away from IHS because of the much greater salary and working conditions they can obtain in private practice. This is of great concern because individuals selected to be trained as CHM's are people who have the most potential for serving in a remote, rural Indian community. If proper appreciation, recognition, remuneration for this type of assignment is denied, one of the major goals of the program will not be reached.

CHEROKEE ALCOHOL AND MENTAL HEALTH PROGRAM

GOAL:

To provide a viable program to reduce the incidence of alcohol abuse, and related mental health problems.

BACKGROUND:

This program was originally established as pilot program for alcohol studies under the parent organization, C.A.P. (Community Action Program) in 1971. Initial funding for this program was in the sum of Sixty-Seven Thousand Dollars for a period of two (2) years. The Mental Health portion having its origin in the C.H.R. (Community Health Representative). In 1973 the two programs were combined to form the present program.

The primary purpose of the program is to seek out, identify and assist those persons exhibiting a problem of alcohol abuse, and to assist those families to cope with the problems and aid in the recovery of those persons displaying the problem. These ends are sought through individual and family counseling, referral to other agencies, and through community education and sensitization.

This program has seen several directors come and go while maintaining essentially the same counselors. The majority of the training for these counselors has been through local, regional, and area workshops, in-service training, and on-the-job experience. Very little formal training has been made available due to the magnitude of the problem which necessitated a counselor immediately upon assuming the position.

Current funding levels are adequate to maintain the program but do not allow for any increases in staff, training, services, and so forth. The magnitude of the problem lies not only in dealing directly with the clients but wiht the general population and the environment which serve to generate a high proportion of recidivism. Implementation of the "Cherokee House" would provide a viable avenue directed towards a partial solution for a number of problems with which we are faced.

OTITIS MEDIA PROGRAM

GOAL:

To effectively reduce the incidence of otitis media through early detections and treatment, and by promotion of better health practices among the Indian people.

BACKGROUND:

The Otitis Media Program is in its fourth year as a tribal contract health care service.

This service has an audiologist-coordinator who through a screening program identified cases of defective hearing. This activity attacks the otitis media syndrome through a program of prevention and referral for early treatment, thereby helping to reduce the surgical backlog and improve rehabilitation programs.

Chapter III : OPERATIONAL PLAN

Administration

Direct Patient Care :

- Medical Care
- Nursing
- Dietary
- Laboratory
- Medical Records
- Psychological Services
- Maintenance

Field Health :

- Public Health Nursing
- Dental Clinic
- Health Education
- Pharmacy
- Environmental Health
- Snowbird Clinic

Tribal Contract Medical Care :

- Alcohol and Mental Health Program
- Otitis Media Program
- CHR Program Plans and Evaluations

OPERATIONAL PLAN: ADMINISTRATION

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Personnel Utilization along with productivity and morale.	1.1 Raise the present level of general activities in areas of management and administrative services program and execution. Employee's training development and community activities.	1.1.1 Develop the effectiveness in on-going programs; fund utilization, fiscal planning, budget and reviewing.	April 1976
		1.1.2 Insure a good staff meeting each month, communication in daily contact with and assistance to the SUD on community and tribal activities.	July 1976
	1.2 Improve service unit incentive awards program; submit at least one suggestion and one superior work performance recommendation each quarter.	1.1.3 Establish a formal cross training program among the supervisiors and future ones in administration.	January 1977
	1.3 Better inform all personnel of local and current IHS policies.	1.1.4 Insure continual operation of "Management by Objectives" system in administration.	January 1976

OPERATIONAL PLAN: ADMINISTRATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
		1.1.5 Encourage employees to participate in improving operation, efficiency and economy.	October 1977
		1.1.6 Publish one personnel bulletin each month.	July 1976

Chapter III : OPERATIONAL PLAN

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Direct Patient Care :

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OPERATIONAL PLAN: ADMINISTRATION

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OPERATIONAL PLAN: ADMINISTRATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
		1.1.5 Encourage employees to participate in improving operation, efficiency and economy.	October 1977
		1.1.6 Publish one personnel bulletin each month.	July 1976

OPERATIONAL PLAN: ADMINISTRATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
2. Direct communication with contract medical care personnel and physicians	2.1 Design and implement an effective and equitable system for planning the allocation of funds.	2.1.1 Implement and utilize a quarterly summary of cost report as a total for future budget request for routine and special treatment.	October 1976
		2.1.2 Develop and implement a method for submitting and follow up on authorization chargeable to contract medical care funds operating to present interruption of service because of lack of funds.	October 1976
		2.1.3 Current commitment register which will provide control of funds at station level.	January 1976
		2.1.4 Compare current printouts (540 & 111) with station commitment register.	January 1976

OPERATIONAL PLAN: ADMINISTRATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
		peak and valley productivity during periods of workloads.	April 1976
3. Property and Supply Management to users directly.	3.1 Develop a better level of on-going operations to include: Routine property and supply matters, fiscal activities, special meetings, coordination and implementation of plan of action.	3.1.1 Study a possible time for delivery on all items being purchased. Delay deliveries if needed.	October 1976
		3.1.2 Remain in constant touch with vendors who will be supplying our needs for any changes and/or delivery times needed.	October 1976
	3.2 To re-organize and plan a layout for efficient receipt, storage, and placement of equipment.	3.1.3 Effect a complete communication procedure at all times with disciplines or individuals concerned with use of new equipment. This will enable the discipline to be absolutely sure that P & S obtain the most efficient and suitable equipment for use in the facility.	January 1977
	3.3 Obtain the best possible source of supply for all items procured for this service unit (according to FPM).		
	3.4 Central improved developed system of reporting and compiling statistical and financial data.		

OPERATIONAL PLAN: ADMINISTRATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
		3.1.4 List all open market type items on an informal bid form. With this listing as an aid, devise a mimeograph form to be mailed to prospective suppliers for their price quotation.	October 1976
		3.1.5 Constant review of commitment register by comparing with expenditures on printout (540 & 111)	April 1976

OPERATIONAL PLAN: MEDICAL CARE

	PROBLEM		OBJECTIVE		PLAN OF ACTION	TARGET DATE
1.	High incidence population for carcinoma of the cervix	1.1	Earlier diagnosis of cervical carcinoma	1.1.1	Routine Pap smear, pelvic exam on all females over 18 years of age	On-going
2.	Inadequate treatment of cervicitis	2.1	Better treatment of cervicitis	2.1.1	Obtain electrocautery unit	On-going
3.	Lack of patient understanding of trichomoniasis with poor treatment compliance	3.1	Better patient understanding of disease	3.1.1	Printout sheets to be given to patients, explaining nature of disease, mode of transmission, importance of treatment	On-going
4.	Inadequate information instruction regarding dietary regimes, ulcer diets, dietary regimes for liproproteinemias	4.1	To increase patient understanding, compliance of dietary regimes	4.1.1	Better, more extensive printed dietary regimes, set aside time for public health nursing to instruct patients	On-going
5.	Inadequate follow-up of suspicion findings of GI fluoroscopy and GI x-ray procedures	5.1	Better evaluation of GI x-ray findings	5.1.1	Utilization of GI endoscopy, gastroscopy, and colonscopy	

OPERATIONAL PLAN: MEDICAL CARE (Cont.)

	PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
6.	Endocrine, metabolic, and blood disorders are felt to be the highest priority health problem at the Cherokee Service Unit. Diabetes accounts for most of the disease in this category.	6.1 Strengthen instructions in clinic setting and provide for more and better home follow-up visits	6.1.1 Re-institute diabetic clinic, specifically to instruct patients on diet, etc.	On-going
			6.1.2 Provide additional personnel so that the above may be carried out to fullest extent	
	Insufficient instructions on diabetic diets		6.1.3 Utilize CHR's	
7.	Improper utilization of medications and lack of compliance	7.1 Improve communication with individual patients	7.1.1 Counsel with patients in the home setting and establish necessary follow-up needs	On-going
			7.1.2 Assist in persuading uncooperative patients or patients who need interpretation to seek appropriate care and continue the prescribed regimen	
8.	Circulatory System Disease:	8.1 Early detection of hypertensive patients and better compliance with treatment programs	8.1.1 Annual or bi-annual routine physical exams to include blood pressure determinations	F.Y. 1977
	Hypertension			

OPERATIONAL PLAN: MEDICAL CARE (Cont.)

PROBLEM	OBJECTIVE		PLAN OF ACTION	TARGET DATE
			8.1.2 Instruct patients concerning diet (low sodium, etc.) and concerning need to follow prescribed plans	
9. ASHD	9.1	Prevention of myocardial infarction	9.1.1 Routine EKG's on all patients over 40 years of age	F.Y. 1977
			9.1.2 Proper dietary instruction (low fats, low cholesteral, etc.)	
10. Cerebrovascular Disease	10.1	Prevention of stroke	10.1.1 Control of hypertension as described above	F.Y. 1977
11. Lack of facilities for complete acute trauma care	11.1	Prompt evaluation and appropriate treatment of minor and major trauma	11.1.1 Continual review and upgrading of E.R. facilities	On-going
			11.1.2 Continue good liaison with referral physicians	On-going
			11.1.3 Seek full recognition of certified physicians assistant already on hospital staff for improved	July 1976

OPERATIONAL PLAN: MEDICAL CARE (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
		E.R. coverage	
		11.1.4 Seek improved E.R. Facilities and "minor procedures" room in new hospital.	
12. High infant mortality	12.1 Improve infant survival	12.1.1 Upgrade sterile technique in delivery room and nursery	On-going
		12.1.2 Continue to promote well baby care and immunization	On-going
		12.1.3 Improve liaison with University of Tennessee for transfer of acutely ill infants	On-going
13. Helminthic diseases endemic to this arch	13.1 Decrease prevalance of helminthic infestation	13.1.1 Combine semi-annual prophylaxies in school age children	On-going

OPERATIONAL PLAN: MEDICAL CARE (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
14. High incident of respiratory disease	14.1 To provide methods of definitive diagnosis, treatment and follow-up of infections and non-infections upper and lower respiratory disease	14.1.1 Increase in number of properly trained nursing personnel	
		14.1.2 Increase in number PHS field nurse or personnel services	
		14.1.3 Increased laboratory function e.g., pulmonary function, quality X-rays, etc.	
		14.1.4 Increased clerks to find and post laboratory studies quickly	
		14.1.5 Increased misttents, isolette, croupette	
		14.1.6 Several ultrasonic nebulizers	
		14.1.7 Compressed air, 5% CO_2 - 95% O_2, Central O_2	
		14.1.8 Contract services as rated in "A"	
		14.1.9 Careful pursuit of prevention medicine, e.g., DPT, TBc screen, etc.	

OPERATIONAL PLAN: MEDICAL CARE (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
15. High incident of renal disease	15.1 To provide methods of definitive diagnosis, treatment and follow-up of infectious and non-infectious renal disease	15.1.1 Increase in number of properly trained nursing personnel	
		15.1.2 Nutritionist	
		15.1.3 Contract services with radiology, nephrology, urology and pathology	
		15.1.4 Increased laboratory personnel and facilities.	
		15.1.5 Available clerks to find and post laboratory studies quickly	
		15.1.6 Administrative moral and economic support	
		15.1.7 Peritoneal disposable dialysis sets, dialysis electrolyte solutions and available nursing assistance available to assist under a trained physician guidance	

OPERATIONAL PLAN: NURSING

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Top priority in Cherokee: Endocrine, metabolic and blood disorders 1. Diabetes Mellitus	1.1 To reduce the need for hospital admissions and outpatient visits to clinics for patients in this category	1.1.1 Diabetic Clinics as separate clinic on October 1, 1975, when appointment system went into effect	PHASE I Started 10/75
	1.2 To reach methods of control and the necessity of staying under control	1.1.2 In cooperation with health educator, and PHS, implement weekly teaching sessions. Some subjects to be covered are: 1. Diet 2. Skin and Foot Care 3. Urine Fx-s, aseptic technique in giving insulin injections and areas to be used action of insulin and oral meds. and importance of staying on regime for control 4. Limit each teaching session to 15 minutes on a given day 5. Place checklist on patient's chart assuring that each subject is covered and understood 6. Periodic reviews	PHASE II - On - going presently discussions being held, gathering teaching aids, etc. PHASE III - Start teaching first January 1976 sessions PHASE IV - Obtain dietition or nutritionist who could be most helpful in this work PHASE V - At some future date, endeavor to involve CHR's in home checks of patient's diet, the condition of skin and feet, care of nails.

OPERATIONAL PLAN: NURSING (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
			urine testing, and if medications are being taken properly
2. Drug Abuse A. Alcohol B. Prescribed drugs C. Illegally obtained drugs	2.1 To recognize the problem and patient's needs 2.2 To develop improved attitudes of nursing personnel toward these patients 2.3 To reduce the need for hospital admission 2.4 To aid in rehabilitating the patient	2.1.1 Hold in-service conference by persons with special training in this field 2.1.2 Work with health disciplines such as mental health workers, schools 2.1.3 Strive to convince these patients they are worthy of rehabilitation	1976 1977
3. Diseases of Respiratory Tract: Common Cold Tbc Emphysema Bronchitis Pneumonia	3.1 To reduce the incidence these infections and the need for hospitalization and clinic visits. At the present time 18% of the patients seen in the outpatient clinic have U.R.I.'s 3.2 To stress the importance of better housing, food and clothing and a general knowledge of	3.1.1 General education of the people through poster, pamphlets, films, and articles on the subject in the "One Feather", etc. 3.1.2 See that new cases of TBC are referred to PHS for follow-up and to OEH	1976

OPERATIONAL PLAN: NURSING (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
6. Gynecological Disease	6.1 Prevention of abnormal gynecological conditions through corrective action and prevention	6.1.1 Periodic breast exams and pap smears and necessary follow-up	On-going with good patient participation
		6.1.2 Prevail upon physicians to keep appointments as scheduled. Recently several patients have left without being seen after having been screened and left waiting several hours	Possibly training of nurses to do pap smears, also teaching them new techniques and update their knowledge about patient teaching
7. Circulatory Disease: Coronary heart disease	7.1 To lower the fatality rate and the nurses role in this as it pertains to this hospital	7.1.1 To update our coronary care unit	When construction funds available 1976
		7.1.2 To reduce existing noise level	
	7.2 To teach patients to live within their cardiac reserve	7.1.3 To acquire a new minitor; in two more years, our present machine will be obsolete and repair parts will not be available	1977
	7.3 Proper screening of cardiac patients		
		7.1.4 To upgrade nurse's role through special training in workshops, seminars, in-service conferences, etc.	1977 All nurses on staff
8. Trauma: Accidents Child Abuse	8.1 To be more aware of causes and	8.1.1 Prevention education for general public through	When teaching aids are obtained

OPERATIONAL PLAN: NURSING (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
	proper reporting	films, lectures, literature, and worthwhile articles in "One Feather" with emphasis on alcohol as a causitive factor in many cases of trauma	
9. Neuropsychiatric Disease: Anxiety Tension Depression Paychosis Developmental Disabilities Cerebral palsy Mental retardation	9.1 How to deal with the emotionally disturbed patient in a general hospital setting	9.1.1 Those nurses with psychiatric training will serve as instructors and advisors of other nurses and para-professionals	
	9.2 Handling the total family	9.1.2 Referrals for consultations with psychiatrists or psychologists	
	9.3 To improve attitudes of nursing personnel through better understanding	9.1.3 Personnel will be encourage to attend workshops and seminars relative to this subject	When staffing permits
		9.1.4 In-service training from local mental health groups and the psychiatrist assigned to	When their time permits scheduling

OPERATIONAL PLAN: NURSING (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
10. Diseases of the genito-urinary tract: Veneral Disease Cystitis Prostatitis Pyelonephritis	10.1 Education as to causes, effects To reduce the need for hospitalization and clinic visits for patients in this category	10.1.1 Prevention through teaching and stressing the importance of staying on regimen of medication and treatment as prescribed. When indicated proper reporting to other health authorities	When more staff is available
11. Infective and Parasitic Disease	11.1 To lower the incidence of these diseases in the community through a teaching program and proper treatment in the hospital and thereby lower the need for hospitalization and clinic visits in the future	11.1.1 Education re: how diseases are transmitted from person to person. By use of poster, films, literature, and appropriate articles in "One Feather." 11.1.2 Work with CHR's; ask them to be on alert for areas of poor sanitation, where toilets are non-existant, etc., and then to report this to OEH workers	When audio-visual aids are obtained (We are now hampered in implementing program because of funds for audio-visual equipment.

OPERATIONAL PLAN: NURSING

PROBLEM UNMET NEEDS	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. A clerical worker for nursing office. The DON and ADON now spend too much time on work of this nature, and we are always behind with reports	1.1 To obtain full-time clerical employee who will be capable of doing routine typing and filing for nursing office and who could also be utilized as a part-time ward clerk	1.1.1 Request clerk-typist	Needed now
2. Two additional staff nurses, one supervisory position. Our outpatient load is increasing and we are understaffed. Our teaching of prenatals and diabetics is virtually non-existant. Screening is difficult because it is often necessary to function with para-professionals and the physicians prefer professional nursing personnel	2.1 Request one supervisor for outpatient clinic. Two additional nurses to cover when sick or annual leave is being taken. (Two temporary nurses are employed at this time and without them we could not function as well as we do)	2.1.1 Request three additional R.N. positions - (One Supervisor - 2 staff nurses)	
3. Security officer for night shift between 10 p.m. and 6 a.m. (Recommended by Dr. Wells, Chief of staff)	3.1 To alleviate the potential danger that the female nursing staff is subject to	3.1.1 Hire a person who would be on duty during the hours of greatest risk	

OPERATIONAL PLAN NURSING (Cont.)

PROBLEM UNMET NEEDS	OBJECTIVE	PLAN OF ACTION	TARGET DATE
4. Additional person for janitorial staff and a periodic assigning of a housekeeping consultant	4.1 To remedy the deficiencies in the cleanliness of the hospital which times could be considered a health hazard to the patients it serves	4.1.1 Have situation assessed by housekeeping consultant and make attempt to abide by his/her recommendations	

OPERATIONAL PLAN: DIETARY

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Lack of Dietition or Dietition Nutritionist with resultant absence of nutritional teaching	1.1 Organization of upgrading of dietary department to meet accreditation standards. To relieve nursing of responsibility of dietary department	1.1.1. Request new dietary position of dietition or nutritionist to give good nutritional teaching both therapeutic and preventive in hospital and field health	Priority under new positions requested
2. Lack of adequate sanitation in dietary department. This is conducive to spread of disease. Dish washer obsolete and parts unavailable -- unable to sterilize dishes and silver	2.1 Obtain new equipment to meet sanitary standards	2.1.1. Request purchase of new dishwasher - Number 1 priority	Needed now-colony counts may warrant use of paper service to all patients
3. Lack of space and food storage area; walk in refrigerator obsolete and badly in need of costly repairs	3.1 To obtain new equipment in order to reduce food spoilage which results in inconvenience to staff in having to make last minute changes in menus, raises food costs, etc.	3.1.1. Request new refrigerator	Needed now-77
4. Employee's all are Wage Board with equal status. There is a lack of employee capability in area of food service to assume added responsibilities needed in food production and service	4.1 Obtain training to devise a method to determine the capability of present employee's supervisory ability and encourage additional training if possible	4.1.1. Closer supervision through revision of past performace evaluation	F.Y. 1976

OPERATIONAL PLAN: LABORATORY - X-RAY

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Inability to consistently complete the usual workload, routine x-rays, filing of x-rays, and maintain equipment due to lack of personnel.	1.1 Be able to complete daily all procedures requested. Keep abreast of large volume of filing, pulling, and refiling of X-ray films, and properly cleaning of equipment and X-Ray room, and do preventive maintenance on equipment.	1.1.1. Have submitted justification for registered Radiological Technologist position to Service Unit Director. Will submit justification for an aide to do filing and attendant work.	F.Y. 77 Cost of $15,000/yr.
2. Inability to perform flurroscopy procedures, and other special procedures, in X-ray and low quality of some of the more sophisticated routine positions.	2.1 Be able to perform fluroscopy procedures on site with a Radiologist present. Be able to give consistent high quality films on any examination requested.	2.1.1. Have submitted justification for a Radiological Technologist to SUD and to Area Office. Chief Medical Officer to contract for reading of films once each week at hospital.	F.Y. 77 When position for Technologist Same as above
3. Inadequate quality control in laboratory procedures.	3.1 Expand and document specific procedures for an adequate comprehensive program to meet accreditation.	3.1.1. Increase quality control tests. Perform inservice education for greater control consciousness. Participate in CAP, CDC, and a regional commercial proefficiency program.	F.Y. 77 Cost of $200/year

4. Lack of comprehensive laboratory and X-ray manual for service unit and for laboratory and X-ray.	4.1 Expand present procedures manual to comprehensive booklet for Service Unit and improve and update procedures manual to hospital certification level.	4.1.1 In cooperation with entire laboratory staff, plan and write both manuals.	F.Y. 77 Cost 160 man hours.
5. Grossly inadequate staffing of laboratory.	5.1 To have sufficient personnel employed: 1.) To insure that personnel perform all tests and quality control measures in a highly professional manner. 2.) To enable laboratory staff to add new procedures that will aid physicians in prompt diagnosis and satisfactory management of patient problems. 3.) To allow laboratory staff to engage in inservice education, to attend workshops on current state of knowledge and participate in mandatory continuing education. 4.) To permit staff to	5.1.1 Submit justifications for new positions to Service Unit Director.	When positions are created.

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
	work only 40 hour week, except for call back duty, and to use earned annual and/or sick leave without creating a genuine hardship on other staff members.		

STAFFING	HAVE	NEED	LACK
Laboratory Technician	3	4	1
X-Ray Technician	0	1	1
X-Ray Aid	0	1	1
Laboratory Aid	0	1	1
Lab X-ray Clerk	0	1	1
Total	3	8	5

OPERATIONAL PLAN: LABORATORY

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
UNMET NEEDS:			
1. Insufficient emergency power system for laboratory.	1.1 To prevent complete shutdown of laboratory operation in the event of power shortage for emergencies and critical patients.	1.1.1 Request installation of emergency outlets.	
2. Breakdown in communication between nursing and laboratory.	2.1 To insure better health care by preventing wasted time in interpretation of orders.	2.1.1 Whenever possible exchange knowledge between departments so that each will better understand the other's function. Workshops needed for interdepartment personnel.	
3. Inadequate equipment to perform coagulation studies accurately.	3.1 To provide the physician with an accurate test in a minimal amount of time, thus providing better care for the patient.	3.1.1 Requisition equipment needed.	
4. Possible fire hazards in laboratory.	4.1 To obtain chemical fire extinguisher and fire blankets.	4.1.1 Formerly requested.	

OPERATIONAL PLAN: LABORATORY (Cont.)

PROBLEM UNMET NEEDS:	OBJECTIVE	PLAN OF ACTION	TARGET DATE
5. Delays in workload output due to not enough microscopes.	5.1 To increase the work effectively.	5.1.1 Obtain microscope for microbiology use only.	
	5.2 To stop possible cross-contamination.		

OPERATIONAL PLAN: MEDICAL RECORDS

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Institution of Appointment System; long waiting time to see the doctor.	1.1 To cut down waiting time for patients, by giving appointments instead of on a first-come, first-serve basis.	1.1.1 Reguisition for another fulltime clerk to assist present receptionist-clerk in pulling and filing charts, making appointments, and assist in filing of late lab reports.	January 1976
		1.1.2 Possibility of obtaining CETA Worker to fill in this capacity.	
2. Staff Cooperation in the institution of the Appointment System; patients with appointments and for special clinics are still having to wait 2-3 hours to be seen.	2.1 To further cut down the waiting time for those patients with appointments and those who have arrived for specialty clinics.	2.1.1 To present these problems which are encountered by Health Records and the Nursing staff when approach by disgruntled patients who have still had to wait a considerable time.	December 1976
3. Institution of color code filing system; obsolete filing system.	3.1 To provide faster accessibility of charts for the Health Record personnel and nursing personnel who pull charts after hours.	3.1.1 Have been checking and thinning charts, breaking them down and removing inactive charts.	July 1976
		3.1.2 Full concentration to this process when all equipment has been received and installed.	

OPERATIONAL PLAN: MEDICAL RECORDS (cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
4. Inadequate storage space.	4.1 To provide a locked storage area for Health Records only for safe-keeping of inactive charts, death charts, and partial charts, prior to their being sent to Federal storage area.	4.1.1 Requisition again to administration to provide such an area.	July 1976

OPERATIONAL PLAN: MEDICAL RECORDS

PROBLEM UNMET NEEDS:	OBJECTIVE	PLAN OF ACTION	TARGET DATE
Inadequate office space	1. Employee counseling 2. Provide adequate space for various office duties.	To request more room for Health Records in new facility.	
Inadequate medical staff library	Provide adequate space for physicians to read and study medical literature.	To request room adjacent to Health Records in new facility.	
Inadequate dictating area.	To provide a separate quiet place for physicians to dictate.	To request incorporation of the dictating facilities into the new library in new facility.	

OPERATIONAL PLAN: PSYCHOLOGICAL SERVICES
MENTAL HEALTH, ALCOHOLISM & DRUG ABUSE PROGRAM

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Emotional Problems both associated and not associated with misuse of alcohol and drugs.	1.1 Increase awareness of existence of these problems in living.	1.1.1 Continue case-finding efforts.	Target dates are not appropriate to these endeavors.
	1.2 Increase acceptance on part of citizen's to seek help for these sorts of illnesses.	1.1.2 Arrange for Rx at IHS facility and outside Rx agencies both outpatient and inpatient.	All are considered to be ongoing efforts.
		1.1.3 Consultations with school, social services, and other agencies.	
		1.1.4 Provide training opportunities, workshops, etc., with hospital staff, etc.	
		1.1.5 Make efforts to coordinate activities of Tribe, BIA, and IHS groups.	
		1.1.6 Increase contact with citizen groups.	

OPERATIONAL PLAN: MAINTENANCE - HOSPITAL SECTION

	PROBLEM		OBJECTIVE		PLAN OF ACTION	TARGET DATE
1.	Hospital kitchen needs repairs.	1.1	Improve to highest sanitary standard possible.	1.1.1	Complete renovation.	2/76
2.	Hospital delivery room needs upgrading.	2.1	Improve to highest sanitary standary and re-arrange for highest efficiency.	2.1.1	Renovate.	2/76
3.	Nurse's call system in need of alteration.	3.1	Make systems more functional and efficient.	3.1.1	Move indicating panel and replace faulty bedside stations.	4/76
4.	Employee's lounge located in drab, poor lighted, and unvented room.	4.1	Improve employee morale by having a suitable place to take a break and have lunch.	4.1.1	Renovate room by paneling walls, drop ceiling, lighting and ventilation.	5/76
5.	Janitors closet in poor sanitary condition.	5.1	Improve to conform to sanitary code.	5.1.1	Tile walls add lighting and shelving.	4/76
6.	Exterior woodwork decayed westside.	6.1	Repair for more attractive appearance and prolong life of building.	6.1.1	Remove and replace.	7/76

OPERATIONAL PLAN: MAINTENANCE - GROUNDS

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Pavement adjacent to hospital in need of repair.	1.1 Repair for more durability and appearance.	1.1.1 Remove vegetation patch and add top coat and seal.	8/76
2. Grounds in poor condition.	2.1 Improve grounds to a more attractive landscape.	2.1.1 Set out shrubbery, trim existing trees, fertilize and lime lawns.	9/76
3. Driveway to quarters # 57 in poor condition.	3.1 Improve for a more convenient and safer approach to building.	3.1.1 Construct driveway and pave.	8/76

OPERATIONAL PLAN: MAINTENANCE - QUARTERS

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Quarter R-3 foundation sinking, leaving bldg. in bad shape.	1.1 Repair to prolong life of building.	1.1.1 Excavate site, fill, compact and relevel house.	2/76
2. Interiors need frequent repainting.	2.1 To eliminate this problem for a saving in manhours and materials.	2.1.1 Panel interiors with a durable finish.	11/76
3. Storage space in quarters, R-1, R-2, R-3, and R-4 inadequate.	3.1 To make quarters more livable and safer.	3.1.1 Construct storage area onto building.	8/76
4. Bathroom floors in Quarters R-1, R-2, R-3, and R-4 decayed.	4.1 Repair woodwork and install ceramic tile to waterproof.	4.1.1 Same as objective.	8/76

OPERATIONAL PLAN: MAINTENANCE - HOUSEKEEPING

	PROBLEM		OBJECTIVE		PLAN OF ACTION	TARGET DATE
1.	There are at present only two housekeeping on staff, making it difficult to keep hospital at an acceptable level of cleaning.	1.1	To up grade to the highest level of cleanliness and sanitation as possible.	1.1.1	Add another employee to housekeeping staff.	4/76
2.	Motivation and training of personnel.	2.1	Keep personnel abreast of all new techniques, procedures, and developments in housekeeping field.	2.1.1	Send personnel to housekeeping classes and schools; also send one employee to bacteriological school for the implementation of cross contamination and infection control program.	2/77

OPERATIONAL PLAN: MAINTENANCE - SAFETY

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Disaster Preparedness.	1.1 Have staff in condition to work efficiently in case of disaster.	1.1.1 Motivate and train staff by having drills, presenting films at staff meetings and obtaining and distributing other training material.	1/76
2. Need detailed comprehensive safety program.	2.1 To provide a safe working environment, also motivate employee's to become more safety prone.	2.1.1 Same as disaster preparedness plan of action, except for the establishment of a safety inspection committee.	1/76

OPERATIONAL PLAN: PUBLIC HEALTH NURSING

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. There is still a large number of diabetics who do not follow diet, medication, and general care instructions.	1.1 To be sure that all diabetics know and understand the basic fundamentals of diet, how to give insulin, and how to take care of themselves, especially foot care.	1.1.1 Prepare an up-to-date listing of Cherokee diabetics.	1/76
2. Some diabetics are not attending clinic as they should.	2.1 To have on record the fact that all diabetics are coming in for regular checks as ordered by the doctor.	2.1.1 Coordinate and plan short programs during diabetic clinic on insulin injection, oral medication, foot care, and diet. Work with nursing on this so they can fill in when public health nursing is away.	1/76
		2.2.2 Visit the diabetics that are delinquent in clinic checks.	2/76
3. There are still a small number of pre-school children ages 0-5 who are behind in their immunizations.	3.1 To have all children ages 0-5 up-to-date on all immunizations within the next year.	3.1.1 Visit the delinquent patients and encourage to come to Well-Baby Clinic.	1/76
		3.1.2 Schedule one special immunization clinic every 2 months until all are up-to-date.	1/76

OPERATIONAL PLAN: PUBLIC HEALTH NURSING (cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
4. There is a substantial increase each year in the number of teenage (12-19) pregnancies in and out of school; 15 in 1973-74. This is in spite of a program in sex education in the high school.	4.1 Decrease by 25% the number of adolescent pregnancies and consequently the number of problem pregnancies in this age group.	4.1.1 Contact the P.E. and Home Economics Departments to see what program is being taught, grades, etc.	1/76
	4.2 To have all teenager prenatals in to clinic early and to be alerted to the dangers and risks that this group encounters.	4.2.1 Furnish materials, films, and anything else that would be of assistance in the teaching of this program.	
5. Some women are still not coming in for prenatal care until late in pregnancy - 3rd trimester.	5.1 To have all pre-natal patients in to the clinic for the 1st visit by the 3rd or 4th month of pregnancy.	5.1.1 Coordinate with CHR's and other field workers to report to Field Health and pre-natals they find.	12/75
		5.1.2 Visit new delinquent prenatals and encourage to come to clinic.	
6. There is a number of women in the age bracket 16-60 who do not regularly come in for a yearly Pap test.	6.1 Have 95% of women in this age bracket in for their test, within the next year and a half.	6.1.1 Plan a program with CHM to hold an evening Pap clinic once a month with hours 4-8, etc.	12/75
		6.1.2 Coordinate a plan with Health Educator to present short films or other material to the mothers in well-baby, prenatal and other clinics.	1/76

		6.1.3 Coordinate with Pharmacy Pap smear file to find delinquent women and visit those who do not respond.	1/76
7. There is a definite need for an organized clinic schedule and follow-up in all areas of health care in the Snowbird area.	7.1 Have regular days for pre-natal, Well-baby, and diabetic clinics.	7.1.1 Plan the foregoing with the CHM.	When the Snowbird Clinic is finished, Proposed 2/76
	7.2 Have at least two days a month to home visit and do any follow-up needed in the Snowbird area.	7.1.2 Set definite priorities and reachable goals of health care for these families.	1/76
8. The staff is inadequate to do the job that needs to be done.	8.1 To add another team - 1 PHN, 1 LPN to the present staff in order to carry out a good and effective field health program.	8.1.1 To request additional staff and space at every opportunity beginning with this program plan and in yearly reports, etc.	11/75

OPERATIONAL PLAN: DENTAL CLINIC

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Inadequate number of trained dental auxilaries at Cherokee.	1.1. To obtain the proper ratio of auxiliaries to dentist.	1.1.1 To prompt Congress to grant two more federal positions of dental auxiliaries.	End of FY 76
		1.1.2 While Cherokee has top priority for these federal positions, the current economic outlook has prompted the President to put a lid on all federal positions; if we are to receive these positions the Tribe must make a special request.	
2. Frequent breakdowns in the dental equipment result in an excessive loss of services.	2.1 Equipment must now be returned to the various dental companies for repair service; there are no trained repairmen in the USET area. This results in excessive down time and loss of service.	2.1.1 To select and train a serviceman for the USET area.	End of FY 77
		2.1.2 One of the currently employed maintenanceman would be selected to attend a maintenance and repair course given at the IHS Hospital in Gallup, N. M.	
		2.1.3 This man would be available for consultation and repair work to the service units in USET.	

OPERATIONAL PLAN: DENTAL CLINIC (Cont.)

3. Lack of equipment for the new Snowbird clinic.	3.1 To provide equipment for the clinic.	3.1.1 Obtain funds via special request from USET.	End of FY 76
4. Improper locals of flouride in the community water supply.	4.1 To properly check and service the water flouridator so that the appropriate amount of flouride is maintained. (optimum levels for this area is .9 pp)	4.1.1 Keeping the proper level of flouride in the water is one of the most effective means of preventing dental decay.	FY 76
		4.1.2 Obtain accurated measuring devices to verify proper levels.	
		4.1.3 Work more closely with OEH and tripal employees involved in the program.	
		4.1.4 Inform and enlist the aid of the Tribal Health Board to correct this problem.	
5. Lack of patient education.	5.1 To educate patients of prevention of dental diseases.	5.1.1 A preventive dental program coordinated with the Health Education Service. CHR's trained in speaking to groups on prevention of dental diseases and demonstrating proper brushing techniques.	FY 77

OPERATIONAL PLAN: HEALTH EDUCATION

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Deficiencies in Consumer behavior in relation to clinical treatment or control of disease	1.1 To improve consumers knowledge, attitude, and behavior in relation to treatment or control of disease	1.1.1 Conduct a study of communication process between clinic staff and consumer	
		1.1.2 Help the other health workers/agencies strengthen their communication process with consumer	
2. High incidence of endocrine metabolic and bland disorders	2.1 To improve knowledge and practice of patients as well as their families concerning their diet, weight control, and exercises	2.1.1 Work cooperatively with the nursing and medical departments in developing an educational program for clinic patients	On-going
		2.1.2 Conduct educational sessions and discussion groups at clinic either in groups or individually concerning diet, weight control, and exercise; also foot care	1/76
	2.2 To improve knowledge and practice of the consumer in better foot care	2.1.3 Develop visual aides to strengthen the educational activity	1/76
		2.1.4 Conduct home visits to discuss and evaluate the diabetic care practices of the family	On-going

OPERATIONAL PLAN: HEALTH EDUCATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
3. High incidence of alcohol and mental disease	3.1 To improve the attitude, knowledge and skill of health staff who work with alcohol and mental health	3.1.1 Contact and discuss with the SUD, psychiatrist, Chief of Staff, DON, the possiblilty for an inservice training program for health workers. Program developed by AHA with grant support from NIH on alcohol abuse and alcoholism and mental health services	On-going
	3.2 To improve knowledge, attitude and behavior of alcoholic patient as well as their families concerning alcohol.	3.1.2 Plan and implement inservice training for staff and allied health workers, including the preparation of material and resource persons	
		3.2.1 Work together with the health staff developing health education activities on alcoholism	
		3.2.2 Work cooperaticely with alcohol and mental health program in developing educational activity and consultation	
		3.2.3 In cooperation with alcohol and mental health program and school authorities develop an educational activity program for school children	

OPERATIONAL PLAN: HEALTH EDUCATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
4. High incidence of respiratory tract disease	4.1 To improve the knowledge and practice of the health consumer concerning respiratory diseases	4.1.1 To identify those families with a high incidence of repeated respiratory disease	1/76
		4.1.2 Make home visits to evaluate health practices by the consumer	On-going
		4.1.3 Develop and implement a health educational program to be used on home visits with families	On-going
		4.1.4 Work with the school health nurse to develop health education activity in the school	1/76
		4.1.5 Develop health education activity for communication	
5. High incidence of gastro-intestinal disease	5.1 To improve the knowledge and practices through health education of the consumer	5.1.1 Work cooperatively with lab, nursing and field health to identify cause of the disease in terms of the agent as well as the behavior which causes the disease	

OPERATIONAL PLAN: HEALTH EDUCATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
		5.1.2 Help the nurse plan and implement educational activity, including preparation and giving recommendation about the education material for the patient	
		5.1.3 Home visits to discuss the cause and how to prevent such disease in terms of consumer behavior	
		5.1.4 Discuss problems as disease in community meetings	
6. Lack of Obstetrical Gynocological Health Education	6.1 Through family planning program improve the knowledge and health practices related to those conditions	6.1.1 In cooperation with Field Health Nurse, DON, and Chief of Staff, develop an educational program for clinic patients, specifically First Visit Program and after delivery family planning	
7. Inadequate base data for educational diagnoses of health problems	7.1 To collect and examine data that will provide more accurate data needed for planning	7.1.1 Contact other agencies which can provide various accurate data	FY 76-77
		7.1.2 Contact and or help other agencies/health workers conduct survey	

OPERATIONAL PLAN: HEALTH EDUCATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
8. High incidence of dental problems	8.1 To improve the knowledge and dental practices of school children K-6	8.1.1 Through a dental program, teach the children to brush correctly, how to determine the kind of toothpaste to use and to floss	1/76 - 2/76
	8.2 To assist teachers in anyway possible to improve their knowledge on dental health	8.2.1 Through the North Carolina Dental Association, arrange a program for teachers.	
9. Lack of information about health careers among high school students	9.1 To increase the knowledge of students about health careers	9.1.1 Develop a classroom program for Junior and Senior High School students	
		9.1.2 Through discussion, field trips, films, and guest speakers from the various health fields endeavor to instill interest and increase knowledge about the health careers	
		9.1.3 Develop the program in such a manner as it can "Spin-off" into a regular classroom activity with a teacher who will work with the health educator until such time of "Spin-off"	

OPERATIONAL PLAN: HEALTH EDUCATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
10. Lack of knowledge of some lay staff who work in the hospital on the life cycle of communicable agents	10.1 To improve the knowledge and practice of the lay workers on the life cycle of the agents, means of cross-contamination within the hospital, so that the group can learn to work with efficiency and without fear	10.1.1 Identify those who need the knowledge	
		10.1.2 Identify the major or existing cross-contaminates and areas of greatest possible incidence	
		10.1.3 In cooperation with DON, Laboratory, OEH, and Housekeeping, conduct in-service training for group	
11. Poor health practices and little knowledge concerning good personal hygiene	11.1 Help to reduce the incidence rate of all other diseases through improved health education knowledge and practices of the consumer	11.1.1 Work cooperatively with other disciplines whenever possible to develop educational activities for the consumers in the clinic and in the patient setting	On-going
		11.1.2 Develop programs such as films, slides, guest speakers, and workshops, that can be taken to the community groups as the need arises	
12. High rate of accidents among service unit population	12.1 To encourage a sense of responsibility for one's safety and that of others through increased knowledge of safety measures and awareness of safety hazards	12.1.1 To develop safety program for industrial complex	3/76

OPERATIONAL PLAN: HEALTH EDUCATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
		12.1.2 To develop home safety program for the consumer and also make posters and other materials geared to inform	
		12.1.3 Continue to encourage enrollment in the first aid class.	
		12.1.4 To secure the assistance of schools and other agencies to develop a defensive driving education course for adults in Cherokee	1977
13. Uninitiated Health advisory members to health, health needs and basic functions of the advisory board	13.1 To assist the health advisory board to be more knowledgeable about Indian Health system and how such a board can effectively function within such a system	13.1.1 In cooperation with present health board membership develop a one-day workshop for all members of board	---1976
		13.1.2 Contact Area Office for assistance with workshop	December 1975
		13.1.3 With officers of the board, determine areas of weakness	January 1976
		13.1.4 Develop a simple system for a brief orientation presentation to be given each year for new board members	September 1976

OPERATIONAL PLAN: HEALTH EDUCATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
14. Lack of orientation program for new IHS employees	14.1 To help new employees to expedite their orientation to a new location in areas of hospital department, shopping and recreational facilities. To help new employee's adapt to and understand Indian culture	14.1.1 Develop a simple map of area locating shopping and recreational facilities	July 1976
		14.1.2 Develop a booklet to contain such information as hospital departments location, name of employee and their title (up-to-date)	July 1976
		14.1.3 Develop slides to use as visual aids for presentation	July 1977
		14.1.4 Form a welcome committee who will arrange for tours, tickets to various programs of interest and other forms of orientation, from community, Tribal Council, health, board, and staff members	July 1976
15. Lack of on-hand good inservice training materials	15.1 To secure materials for in-service training for all staff groups	15.1.1 Purchase when possible audio-visual aids	F.Y. 77
		15.1.2 Reproduce where possible audio-visual tapes	

OPERATIONAL PLAN: HEALTH EDUCATION (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
	15.2 To increase the knowledge capability of staff to handle emergency cardiopulmonary resuscitation thru a basic training program	15.1.3 Keep up-to-date audio-visual tape and film resource materials	
		15.1.4 Set up cards index - locator system for resource materials to purchase, to rent and to secure without charge	September 1977
		15.2.1 Request purchase of Resusi-Anne	F.Y. 77
		15.2.2 Implement training program for all staff	

OPERATIONAL PLAN: HEALTH EDUCATION

PROBLEM UNMET NEEDS:	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. Due to physical deformity of left wrist which has developed' some deterioration, driving the service unit cars with standard steering has become increasing difficult and hazardous	1.1 To obtain automobile with automatic steering for the use of the Community Health Educator	1.1.1 Written request that automobile be purchased 1.1.2 Obtain medical statement of evaluation of condition of wrist	As soon as funds are available
2. Community Health Educator has not had the routine services of office help. Such services as filing and other related duties are performed by the Community Health Educator. Only the minimum amount of typing is done at this time by one of the administrative clerks	2.1 To obtain full-time secretarial service in order that the Health Educator may be relieved from duties which are normally performed by office help	2.1.1 Formally request that secretarial position be reassigned to Health Education	As soon as possible
3. Office equipment will be needed in order for the secretary to perform office duties	3.1 To obtain typewriter and calculator		As soon as secretarial position is made available

OPERATIONAL PLAN: PHARMACY

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. All Weekday IV Additives	1.1 To do most of IV additives during the day time hours under Laminar flow hood	1.1.1 To have better communication and have a pharmacist check on rounds each morining	Already started To be in full operation by January 1976
2. More comprehensive patient consultation	2.1 To do more detail consultation and documentation in patient's chart for OTC and refills	2.1.1 Spending a little more time and getting more detailed history	Now and Feb. 1976
3. Proper Pap Smear Follow-up	3.1 Plans for better follow-up of patients with Class II, Class III, and Class IV	3.1.1 Follow up by better record follow-up and by Public Health Nurse, phone and letter	January 1976
4. Expanding Florida Drug Orders	4.1 Plan to provide more non-formulary drugs to 4 Florida clinics to reduce contract cost. To see that personnel understand about ordering. To check on inventory level	4.1.1 To visit and review ordering techniques. Talk with all ordering personnel. Plan to visit facility to examine storage, outdates, excesses, etc.	January 1976
5. Irregular Inservice Training	5.1 To have a regular inservice training session	5.1.1 Communicate with nursing and other departments to plan training around desires and needs	Already implemented to some extent February 1976

OPERATIONAL PLAN: PHARMACY (Cont.)

PROBLEM		OBJECTIVE		PLAN OF ACTION	TARGET DATE
6. TDY	6.1	Do not plan to provide to Mississippi Service Unit	6.1.1	Do not plan to provide coverage unless emergency	Current
7. Building Plans, Remodeling	7.1	To assist service unit director in any way needed, also would like to work in planning program of the new hospital	7.1.1	Plan as needed	As needed
8. Irregular public news release	8.1	Plan to make patients more aware of services and health tips	8.1.1	Plan to write article on health, pharmacy related matters and submit to local paper for publications	February 1976
9. Physician-Pharmacist Consult (In-Pharmacy)	9.1	Improve rapport with physicians	9.1.1	Plan to always find an answer when requested. Let physician know our concern in helping and being an active part of health care delivery team	Now - Jan. 1976
10. Comprehensive Poison Prevention	10.1	Plans for school contest with poster drawings	10.1.1	Plan to work this in with "Tribal Health Fair" in March 1976. Plans for poster and pamphlet handout to students as well as general public	March 1976

OPERATIONAL PLAN: PHARMACY (Cont.)

	PROBLEM		OBJECTIVE		PLAN OF ACTION	TARGET DATE
11.	Pharmacy-Therapeutic Committee	11.1	To have a separate P & T meeting held each quarter	11.1.1	Plan to have meeting held separate from other meetings, plan for all members to be notified and given an agenda on week prior to meeting	Currently - More input by all members in 3rd qtr. 1976
12.	Need to be doing more refills	12.1	Desire to do more chronic monitoring and following refills	12.1.1	Have acceptance of pharmacy policy and procedure manual and follow	3rd Qtr. 1976
13.	Unplanned Unit dose	13.1	Have a functional unit dose system	13.1.1	Plan to have a written accepted plan of action, visit other facilities and plan extensively	January 1977
14.	Chart Review	14.1	Have a pharmacist reveiw most inpatient charts daily	14.1.1	Change schedule to allow more time in inpatient care	Started Nov. 1975 - Hope to improve Feb. 1976
15.	Prepacking	15.1	To meet all needs of prepackage drugs for Cherokee and Florida Service Unit	15.1.1	Buy as much as possible already prepacked. Keep ample bulk supply on hand for prepack. Keep priority list for prepack worker to prepack	February 1976

OPERATIONAL PLAN: PHARMACY (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
16. Ordering	16.1 To give drug ordering responsibility to supply clerk	16.1.1 Implement automated drug ordering	1st. qtr. 1976
17. Over-the-Counter Program	17.1 To provide more of this service	17.1.1 Make population more aware of the service, via newspaper	January 1976
18. Snowbird Clinic	18.1 To provide more comprehensive drug distribution and pharmacy coverage for new clinic	18.1.1 Plan for pharmacy coverage for proposed large clinic once a week. Provide all drug needs in prepackage form. Keep restocked, checked, and operated in a professional manner	March 1976

OPERATIONAL PLAN: PHARMACY - DISEASE CATEGORY PRIORITIES

PROBLEM		OBJECTIVE	PLAN OF ACTION		TARGET DATE
1. Endocrine	1.1	Pharmacy input in assisting physicians and patients	1.1.1	To assist via chronic monitoring as recorded in Policy and Procedure Manual. Plan for increase amount of reteaching and instruction in related data to medication taking, importance of such, dietary regimen and other pertinent data	3rd. Qtr. 1976
2. Misuse of Alcohol and/or Drugs	2.1	Pharmacy input in assisting physicians and patients	2.1.1	Plan to provide all medication needed, plan to participate in consultation, teaching in any manner as suggested by physicians	3rd Qtr. 1976
3. Respiratory	3.1	Plan for more pharmacy participation	3.1.1	Follow pharmacy policy and procedure manual for OTC operation. Make patients more aware of such through MD referral, Health Educator and local news media	3rd Qtr. 1976
4. Gastro-intestinal disease	4.1	Participate in more detail through pharmacy health delivery team	4.1.1	Provide all medication needed. Provide concise direction and instruction to those in need	3rd Qtr. 1976
5. Obstetrical Synocological	5.1	Assist in any manner needed	5.1.1 5.1.2	Continue on-going Pap program Continue instruction and directions with birth control pills	3rd Qtr.1976

OPERATIONAL PLAN: PHARMACY - DISEASE CATEGORY PRIORITIES (Cont.)

PROBLEM		OBJECTIVE	PLAN OF ACTION		TARGET DATE
			5.1.3	Provide all medication and instructions needed	
6. Circulatory System Disease	6.1	Assist the Health Team in any manner possible	6.1.1	Supply all medication needed for this disease category	4th Qtr. 1976
			6.1.2	Provide any instruction drug related to such	
7. Neuropsychiatric Disease	7.1	Assist the health team in any manner possible	7.1.1	Team work with physician, social worker, or delivery team	3rd Qtr. 1976
8. Trauma	8.1	Be an effective team supporter	8.1.1	Provide all medication, dosage and instruction needed	3rd Qtr. 1976
9. Genito-Urinary Tract	9.1	To be an asset to team support to meet problems demands	9.1.1	Work in conjunction with physician and laboratory personnel, provide all medication needed, provide instruction and direction as needed.	3rd Qtr. 1976
10. Infective and Parasitic Disease	10.1	Be an asset in treating and controlling the incidence of this category	10.1.1	Continue OTC treatment for such as needed	Current
			10.1.2	Continue mass school and day care treatment program	

OPERATIONAL PLAN: PHARMACY - DISEASE CATEGORY PRIORITIES (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
		10.1.3 Plan March re-evaluation of incidence through stool collection and working with CDC, Atlanta	
		10.1.4 Instruct and teach of control measure	

OPERATIONAL PLAN: PHARMACY

PROBLEM		OBJECTIVE	PLAN OF ACTION		TARGET DATE
UNMET NEEDS:					
1. Pharmacist Shortage 1. six pharmacists shortage 2. five pharmacy technicians	1.1	To bring to standards set by PHS	1.1.1	When available	
2. Training (Designated amount per person per year)	2.1	To continue to learn new ideas	2.1.1	When available	
3. Present labeling machine outdated	3.1	To meet expanded needs of prepacking and labeling	3.1.1	To submit requisition	

OPERATIONAL PLAN - Environmental Health

Problems	Objective	Plan of Action	Target Date
1. Home Safety Cherokee has the highest rate of falls and injury in the USET area.	Reduce the accident and injury rate by the greatest number possible.	1. Train Allied Health workers in home safety. 2. Community involvement by meetings.	Nov. 1977
2. 1.0 Water Surveillance 1.1 Sampling of Individual and Community water systems takes valuable time.	1.1 Chemical and Bacteriological water sampling of community water systems. 1.2 Chemical and bacteriological water sampling of individual water systems. 1.3 To insure safe residuals of chlorine and fluoride in main water systems.	1. Institute a program of routine sampling and re-sampling of community and individual water supply systems through Allied Health workers. 2. Train Allied Health Workers the proper way to disinfect community and individual water supply systems. Train Tribal Water & Sewer employees to perform necessary tests on chlorination and fluoridation also in testing solid waste.	On-going

OPERATIONAL PLAN - Environmental Health (Cont.)

Problems	Objective	Plan of Action	Target Date
3. Insects and Rodents	To reduce the incidence of insects and rodents.	1. In cooperation with Health Education, plan a good environmental program for homemakers. 2. Through workshops, train Allied Health workers in a program to motivate reservation residents in vector and rodent control.	Nov. 1977
4. Dog Control Rabies is a constant threat Large number of stray dogs in the area, many of which have never been vaccinated.	To introduce measures for the control of dogs, which have never been vaccinated. To encourage the people to have their animals vaccinated for rabies.	1. Seek the cooperation of tribal planning and investigate the animal control program. 2. Present a program of codes and ordinances relating to animal control to tribal council. 3. Reduce the number of stray animals through a reservation dog pound.	Nov. 1977

OPERATIONAL PLAN - Environmental Health (Cont.)

Problems	Objective	Plan of Action	Target Date
5. Radioaction	To reduce the threat of radioaction explosion to IHS employees and patients.	A regular inspection of radioaction machines A routine check of TID Radioaction badges being able to have proper chemicals in which to have X-ray machines checked. Use of protective clothing for patients. Personnel Radiation Monitoring Surveillance	June 1976
6. Unplanned requests reduce the time for environmental health program activities	To reduce the possibility of unplanned requests from tribal officials.	1. Incorporate in the program planning, the needs of the tribe. 2. Complete involvement of tribal officials in the program planning activities.	On-going
7. Epidemiological Investigations Water & Food born diseases are ever present in Indian communities	To reduce the number of water and food born diseases to the lowest possible number.	To compile, review and evaluate referral on communicable diseases.	On-going

OPERATIONAL PLAN - Environmental Health (Cont.)

Problems	Objective	Plan of Action	Target Date
8. Semi-annual food service surveys of institutional facilities are long over due.	To make comprehensive institutional health surveys	Schedule institutional surveys for food services for the Cherokee Service Unit, make surveys, write and distribute reports and followups.	Nov. 1977
9. Codes and Ordinances Lack of codes and ordinances relating to environmental health program on the reservation.	Tribe has codes and ordinances	1. Relate to the Tribal Officials the need of certain codes and ordinances pertaining to the reservation 2. Close involvement in the planning of the codes and ordinances with Tribal officials.	Nov. 1977

OPERATIONAL PLAN - Environmental Health (Cont.)

Problems	Objective	Plan of Action	Target Date
10. Mutual Help (houses) Site review, plot review, chlorination of water system takes valuable time in the Environmental Health Program.	The Allied Health Workers working in the OEH program will be helping in the mutual help program.	Allied Health workers are being trained to chlorinate water systems, site review, plot, design and percolation tests.	On-going
11. Solid Waste 1. Areas of solid waste being dumped on the reservation other than sanitary landfill.	Encourage the people to use sanitary trash containers.	1. Code and ordinances against solid waste being dumped on reservation other than sanitary landfill.	On-going
2. Unsanitary trash containers being used by the Tribe.		2. Relocation of new sanitary landfill.	
3. Existing sanitary landfill is at its completion.			
12. Home Maintenance Homeowners have continuous problems with water leaks, plugged drains and other breakdowns of individual sanitary facilities.	Institute a program of providing training to all homeowners in proper maintenance and care of all these facilities through trained Allied Health Workers	1. Schedule training programs of community meetings. 2. Home visits. 3. Furnish a homeowner's guide of the sanitary facilities.	Nov. 1977

SCHEDULE OF MAN-DAYS PER YEAR

Home Owner's Training	3/per day	50/man days per year
Perc. Test	½/man days ea.	75/man days per year
Complaints	8/hrs. week	26/man days per year
Meetings: Council Community Services Housing Authority Health Board Miscellaneous		
Water Samples	250 sep.	25/man days per year
Millpose Filter	10/man days	
Rabies: 7 communities	5 days/comm.	35/man days per year
Cherokee Festival: Includes pre-festival and consultation inspection.	2½/man days Concession Water, Sewage and garbage	5 man days
American Legion Carnival (2 weeks)	Concession Water and Sewage and garbage	3/man days per year
Ramp Festival (1 day)	Concession Water, Sewage and garbage	1/man day per year

Plan Review BIA & IHS fact.		2/man days per year
Sanitary Landfill includes Operator Training	1/man day Mo.	12/man days per year
Water Test Cherokee System Chlorine & Fl.	5/hrs. week	33/man days per year
Cherokee Festival	Concession, Water, Sewage and garbage	5/man days per year
Ramp Festival	Concession, Water, Sewage and garbage	1/man day per year
Water samples Comm. Sep.	2 Comm. - 10 samples/mo.	12/man days per year
Water samples Ind. Sep.	100 Sep. C & B	10/man days per year
Sewage Plant Inspection	1/man day/mo.	12/man days per year
Inst. Food Surveys 2 PHS 2 BIA 2 Head Start	1/man day each	6/man days per year
Day Care Surveys 5 (five)	1/man day each	5/man days per year
Civic Center 2 times per year	1/man day each	2/man days per year
Home sites (2 hrs. ea.) (200)		10/man days per year

Citizen Complaints	4 hrs. per week	26/man days per year
Training IHS Staff		10/man days per year
Administration	1/man day per week	52/man days per year
Meetings Tribe 3 Community Services 1¼ Housing Authority 1 Health Board 1½ Miscellaneous 3		15/man days per year
Training Inst. Food Handlers 3/man days Housekeeping 3/man days		6/man days per year
Indust. Hygiene White Shield Cherokee Vassar	½/man days each	2/man days per year
Swimming Pools Chlorine Ph.	check once week	1/man day per year

OPERATIONAL PLAN: SNOWBIRD CLINIC
COMMUNITY HEALTH MEDIC

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
1. New Clinic - Snowbird Area	1.1 Establish Clinic to fullest potential thus providing the best comprehensive patient care.	1.1.1 Clinic to open from two times a month to five days a week over a period of several months; depending on the needs and desires of the people.	Completion of Clinic Proposed 2/76
		1.1.2 To include all special clinics such as: Well-child, Prenatal, Diabetic, Cancer screening, and routine patient care. These services are to be provided by C.H.M.	

OPERATIONAL PLAN: ALCOHOL AND MENTAL HEALTH PROGRAM

	PROBLEM		OBJECTIVE		PLAN OF ACTION	TARGET DATE
1.	There continues to be high incidence of alcohol abuse among the adults of the Eastern Band of Cherokee Indians	1.1	Reduce incidence of this recurring problem	1.1.1	Provide individual and group counseling sessions, provide referral services to area treatment centers, to conduct follow-up and supportive services to the individuals	On-going
2.	Drinking incidence among high school students continues to increase	2.1	Education of students concerning immediate and long-range implications of alcohol abuse	2.1.1	Provide education services through posters, handouts and motion pictures designed within the context of preventive education	On-going
				2.1.2	In working with school officials to establish and maintain an extension office within the school where a staff member may be available at designated times	2/76
3.	Community involvement and sensitivity to the proportion of the problem is minimal	3.1	To educate, sensitize, and open channels between the program and the community	3.1.1	Through use of mass media communications within the community setting, i.e., community clubs and various local organizations to encourage community support and participation	On-going

OPERATIONAL PLAN: ALCOHOL AND MENTAL HEALTH PROGRAM (Cont.)

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
4. No institutional situations offering intermediate shelter, consultation, and rehabilitation	4.1 Provide situational environment wherein these problems may be resolved	4.1.1 See Addendum 1. Locate funding sources, secure fiscal plans, staff and implement program within the cultural context	1/77
5. Staffing inadequacies	5.1 Increase size of staff	5.1.1 Secure funding resources for four (4) additional positions via state or federal grants (2 youth counselors, 1 alcohol counselor and 1 mental health counselor)	6/76
	5.2 Increase training of staff	5.1.2 Schedule intense in-service training on local and regional levels. Secure additional funds for objective	1/76
6. Lack of communication, cooperation, and consideration between existing programs	6.1 Increase communication, cooperation, and consideration	6.1.1 Implement series of workshops and inter-staff sessions to increase the individuals sensitivity to other programs and himself, to avoid duplicity in services	To implement by 2/76

"CHEROKEE HOUSE"

CHEROKEE MULTIFACET COMMUNITY TREATMENT CENTER

PURPOSE AND NEED

PREPARED BY:

CHARLES JAMES HORNBUCKLE

LAURENCE ARMAND FRENCH

CHEROKEE MULTIFACET COMMUNITY TREATMENT CENTER: "CHEROKEE HOUSE"

Statement of Purpose and Need:

The Eastern Band of Cherokee Indians situated on the 56,000 acre Qualla Boundary has urgent need for a multifacet community treatment center to service both sexed youth and adults. The main purpose of this facility is to provide rehabilitative, preventive and reintegrative services within the Cherokee cultural environment. Currently, and in the past, legal dispositions for delinquent, criminal, alcoholic and mental and emotional problems has taken the Indian client away from his cultural environment. Often this exacerbates the situation complicating the client's problems. An this is only half the story. All too often the professionals and para-professionals mandated to help the Indian client have difficulty empathizing with the Cherokee's need.

Reliable cultural and historical sources document the cultural differences between the Cherokee "Harmony Ethic" and that of the surrounding dominant white culture, that of the Protestant Ethic. Well meaning service personnal, enculturated within the Protestant Ethic, fail to realize that they perceive things through their cultural perspective. This is acceptable as long as those being treated share a similar cultural perspective. However, when the clients come from a different cultural setting one that varies considerably from the Protestant Ethic, then a conflict situation emerges, one that frustrates both the professional and his client. This type of ethnocentrism may well account for the high proportion of failure of Indian treatment in white run, off-reservation treatment centers.

What we propose is a Cherokee staffed, Cherokee operated multifacet community treatment center to be located within the Qualla Boundary with the specific purpose of serving Indian clients.

As the situtation stands today Cherokee youth and adults with legal or emotional problems are handled by county, state or Federal agencies. And when institutionalization results, Cherokee clients are placed in off-reservation facilities along with non-Indian inmates. This places the Cherokee at a distinct disadvantage due to (1) his minority representation among the inmate population and (2) his different cultural heritage.

Youth precessed for delinquent or undisciplined acts are brought before the state's 30th judicial district court where the judges and court counselors are all white. About twenty youth per month are adjudicated through this system. If institutionalization results then the Cherokee youth is sent to one of the state's six juvenile detention centers. Those on probation are placed in the custody of the court counselors.

Nearly one-hundred Cherokee adults are either on parole, probation or incarcerated in any given month. Temporary state custody involves the use of the county jail where two young Cherokee men recently committed suicide. Federal serving institutions are located all over the United States, the closest being the Federal penitentiary in Atlanta. State serving institutions consist of 77 adult penal facilities located throughout the state. Indians are the minority in either penal system.

Another three dozen youth a month become dependent due to a lack of parental care or due to emotional, alcohol or drug related problems. Presently the Cherokee Children's Home houses 19 of these youth, but additional facilities are badly needed as well.

Some 250 adult alcohol related contacts and another 150 mental or emotional case contacts are handled monthly by the Cherokee Alcohol and Mental Health Program. The closest detoxification center, as well as the nearest state mental hospital are over 110 miles away.

"CHEROKEE HOUSE": Who It Will Serve

This multifacet community treatment center will have six basic units each serving a specific functional need that currently goes unmet.

1. A youth halfway house for delinquent, undisciplined and run-away cases.
2. Alcohol and drug resident treatment center including a detoxification unit and special youth facility.
3. Transient residence facility for emergent conflict or retreatist situations. This will be a walk-in motel-like facility for those who feel they need to immediately leave intolerable situations. It will serve both males and females of all ages and will consist of two different units - one for the depressed and one for the agressive. Pool tables, television, books and other escapist mechanism will be located in these facilities.
4. A half-way house for Federal and state parolees, probationers, intermediate and work release misdemeanors and felons. It will provide sleep-in facilities, as well as permanent detention services.

5. A separate group home facility for unwed young mothers and expectant mothers.
6. A half-way house facility for intermediate release mental patients and a preventive detention unit for mildly emotionally disturbed or depressed persons and for alcohol troubled patients. For example, temporary living quarters and care can be provided for manic/depressives satisfactorily responding to lithium treatment.

Conjugal visitation arrangements will be provided to those facilities where relevant, as well as adequate visitation hours for friends and relatives. Another must is meaningful individual and group recreational facilities such as pin-ball machines, pool tables, boxing, television, movies, stereo equipment, dances and magazines.

The staff and personnel will include a resident psychologist and nurse, an on-call medical doctor, consultant psychiatrist and a sizeable staff of Cherokee para-professionals.

OPERATIONAL PLAN: OTITIS MEDIA PROGRAM

PROBLEM	OBJECTIVE	PLAN OF ACTION	TARGET DATE
A. Otitis media screening indicates a high incidence of otitis media in the Cherokee Indian population.	A. To prevent advanced otitis media and permanent hearing loss from middle ear conditions.	1. Tribal officials and health personnel will: (a) Provide for the continued training of an otitis media screening technician for the Cherokee Indian tribe. (b) Set up an on-going screening program for children and adults in order to facilitate early diagnosis and treatment. (c) Refer persons who show evidence of otitis media to reservation clinics for follow up.	July 1,1976

OPERATIONAL PLAN: OTITIS MEDIA PROGRAM (Cont.)

OBJECTIVES	PROBLEM - HOW THEY ARE TO BE OVERCOME	IMPACT	TARGET DATE
A. To identify and diagnose pupil referrals having or suspected of having hearing problems.	a. Pupils who exhibit or are supsected of having hearing problems will be referred through the local speech clinicians, teachers, nurses, etc. b. Hearing-otoscopic evaluations will be conducted; pupils will be evaluated in sound proof suite using pure/tone and bone audiometry. Referrals will then be made to physician/specialist of for further evaluation when indicated. Continued follow-up will be made relative to these pupils.	Charts will be maintained as to pupils seen in the otitis media program for diagnostic/intervention services. Statistical records will be kept to denote numbers evaluated, recommended services, and follow-up information as to deposition of these referrels.	On-going

PROGRAM PLAN AND EVALUATION - OTITIS MEDIA PROGRAM (Cont.)

OBJECTIVES	JUSTIFICATION	PROBLEM - HOW THEY'RE TO BE OVERCOME	IMPACT
A. To assist in the identification of the present pre-school children who exhibit or are suspected of having hearing problems	It has been proven that the earlier the identification and remediation the greater the chances for better academic and personal health improvement.	a. Screening for hearing will be scheduled in each pre-school program b. Children who remain in the home will also be accepted for these services. The parents will contact the staff of the otitis media program for referral information.	Data will be kept relative to the number of children screened/ referred to the otitis media and the resultant remediation services. TARGET DATE: On-going

PROGRAM PLAN AND EVALUATION - OTITIS MEDIA PROGRAM (Cont.)

OBJECTIVES	JUSTIFICATION	PROBLEMS - HOW THEY'RE TO BE OVERCOME	EVALUATION
A. To locate and provide diagnostic, referral/ remediation services to those school age persons who are presently excluded from school programs due to handicapping conditions on the adult population who have or are suspected of having a hearing problem	Society is responsible for these elements as well as younger ages. Even though many of these hanicapping conditions are permanant, much can be done to provide greater commucative abilities; this would enhance this improvement.	The technician will provide hearing services to clients of the Cherokee Sheltered Workshop. Adults will be seen by appointment. Referral of persons having otitis media or permanent losses will be referred to appropriate sources for necessary care.	Clients in the Sheltered Workshop should make greater progress in their work skills after hearing problems, if they exist, are diagnosed and remediated. The adults will be able to communciate better if their hearing problems are diagnosed and remediated. TARGET DATE: On-going

PROGRAM PLAN AND EVALUATION - OTITIS MEDIA PROGRAM (Cont.)

OBJECTIVES	JUSTIFICATION	PROBLEMS - HOW TO OVERCOME	IMPACT
To cooperate with local agencies/representatives in expanding services to identified persons.		a. Meetings will be scheduled with Health Education and local health committee regarding the referral and scheduling of the otological clinics. b. Meetings will be held with the regional Vocational Rehabilitation counselors to obtain services for pupils ages 14 and older who could not qualify for services from agencies supporting a younger age.	a. Otological clinics will be conducted in the Cherokee Indian Hospital during the 1976-1977 year. Statistical information will be made available regarding the number seen in clinics and follow-up care. b. Services are to be obtained from VR for persons in need beyond the age that the Crippled Children's Branch provided. TARGET DATE: On-going

PROGRAM PLAN AND EVALUATION - OTITIS MEDIA PROGRAM (Cont.)

OBJECTIVES	JUSTIFICATION	PROBLEMS - HOW TO OVERCOME	IMPACT
B. To utilize referral agencies/services to obtain more intense services.	Follow-up care is absolutely necessary if any remediation is to take place otherwise the program would be futile if only provided for screening and diagnosis	Preschoolers, pupils, or adults who exhibit a hearing loss will be referred to physician/specialist if the type loss indicates this need. In the more severe and questionable cases referrals are to be scheduled at Western Carolina University/Asheville Orthopidic Hospital. This will provide for more intense evaluations - hearing aid evaluations. Crippled Children's Section of the Department of Human Resources will be utilized; to special otological clinics with the necessary medication, surgical follow-up will be funded through the otitis media program.	Data will be kept relative to contacts made with representatives of cooperating agencies, how these referral sources were utilized in obtaining greater services for the children identified as having communicative deficits, and the problems which were remediated through these services. TARGET DATE: On-going

PROGRAM PLAN AND EVALUATION - OTITIS MEDIA PROGRAM (Cont.)

OBJECTIVES	JUSTIFICATION	PROBLEMS - HOW TO BE OVERCOME	IMPACT
To provide for dissemination of otitis information relative to the otitis media program its functions, objectives, cooperation with educational/medical forces in eliminating hearing impairments.		The local unit is to be responsible for newspaper articles and/or special programs regarding purposes, objectives, and accomplishments of the otitis media project. Interviews with newsmen in the local unit, information regarding background/ funding of the program and statistical data will be provided to these newsmen for their articles. Meetings with medical forces, interested groups, designated educational meetings, etc. will be included in order to provide for greater awareness of the otitis media project.	It is contended that this public awareness through these avenues will lead to many inquiries and referrals to the otitis media program for hearing diagnostics. These referrals will primarily be from adults. Through these disseminating activities more public awareness is indicated and a greater number of referrals are likely. Also greater understanding of the impact of hearing handicaps on the total functioning of persons and the necessity for their remediation will be more apparent as more persons learn of this program. TARGET DATE: On-going

PROGRAM PLAN AND EVALUATION - OTITIS MEDIA PROGRAM (Cont.)

OBJECTIVES	JUSTIFICATION	PROBLEMS - HOW TO BE OVERCOME	IMPACT
To increase the knowledge/skills used by the personnel involved in the special programs.	With new developments in the field of hearing evaluation, an ongoing in-service to gain information is a necessity. Increased training would provide improved services and a more accurate program.	Workshops and inservice training sessions will be attended by the staff. Information can be assembled around those areas indicated by the personnel as areas where greatest assistance is desired.	Selected workshops will be attended relative to the needs indicated by the hearing clinicians. TARGET DATE: On-going

CHR PROGRAM PLANS

AND

EVALUATIONS

Submitted By: Charlotte Taylor
CHR Director

Prepared By: Gary Carden
Program Planner

INDEX

II. Revision of 1969 statement of purpose and services. (utilized from 1969-1975)

Shortly after the completion of the 1969 statement of purpose and services, the Cherokee Community Health Representatives Program revised seven (7) major areas of service (reducing them to six), and expanded the number of activities which would be performed by the CHR staff. Essentially, this revision was the logical result since the CHR staff quickly discovered that (a) some areas of critical need were not included in their original statement; and (b) some areas of need anticipated by the CHR staff did not develop. The revised statement is of particular interest since it represents an attempt to correlate the specific, verifiable needs of the Cherokee people with the resources (existing or potential) of the Cherokee Program. In the following outline, the major headings (A-F) indicate the major areas of service which are sub-divided into specific activities.

A. Maintenance of Tribal and individual sanitary facilities.

1. Help other health resources in determining enviromental deficiencies.
2. Sanitary health facilities have only been in existence over a period of ten years, but it has been brought to the attention of Tribal officials that septic tanks, drain fields, etc. are in need of cleaning. We feel we should have the means (equipment) which would enable us to complete the necessary renovation, cleaning, drying out, etc.
3. Provide maintenance and repair for springheads, indoor plumbing and water and sewer lines.
4. When advisable, contact other agencies and inform them of the unclean, crowded and dilapidated condition of the homes; request their assistance in alleviating these health hazards.

B. Health Instruction to families and communities.

1. Interpret and explain instructions, demonstrations and educational materials which are given to our Indian people by hospital and clinic employees and other health-related agencies, services and organizations.
2. In instances where complex language and technical terminology is used (pamphlets, booklets, written instructions) to explain health services and sanitation facilities, the CHR staff will provide the same assistance as designated in #1.
3. Interpret patient needs to hospital and clinic employees; assist in establishing and maintaining positive communications between doctors and patients.
4. Relay any and all information which will improve communications and understanding between the Cherokee people and the Public Health Service.

The acknowledged purpose of this report is as follows: (1) to specfically define the past and present objectives of the Community Health Representatives Program; (2) to evaluate the CHR Program's ability to perform the aforementioned objectives; (3) to identify specific areas of inefficiency and/or inadequacy; (4) to make specific recommendations for the improved efficiency and operation of the CHR Program; and (5) to provide a five-year projection of services, functions, and responsibilities, this projection will be correlated with #4 (specific activities which must be implemented in order to assure future CHR expansion, versatility and capability).

The Cherokee Community Health Representatives Program has undertaken the completion of this report for several significant reasons. The Program staff sincerely hopes that the information, evaluations and recommendations will: (1) provide the CHR staff with a clear understanding of our present and future goals, resources and potential; (2) provide all components of the Cherokee health delivery system with a clearer understanding of the function and scope of the CHR Program; (3) emphasize the definite need for coordination of resources between the CHR Program and any and all Tribal health service programs; (4) provide the Indian Health Service with a comprehensive understanding of the CHR Program (strengths, resources, weakness and potential): and (5) serve as a basis or reference for the improvement of the CHR Program, present and future. Certainly we would hope that our Tribal health services and the Indian health Service will investigate the possibility of initating a number of specific activities designed to eleminate the inadequacies and inefficiencies stipulated in this report.

1. The purpose and services of the Cherokee Community Health Representatives Program in 1969.

   In 1969, the Cherokee Community Health Representatives Program issued a statement which defined the overall purpose of the Program and identified the specific services which the program would supply. The Program's objective was defined as follows: "to reduce disease and sickness in the community by extending the general and enviromental health services currently available and made available in the future." Following this statement of purpose, the 1969 report identified seven (7) major areas of service:

   1. Instruction on maintenance of Tribal and individual sanitary facilities.
   2. Health Instruction to families and communities.
   3. The operation of an information and referral system in which all available health resources would be indentified and utilized to support the Indian Health Service Programs.
   4. Implementation of a Follow-up Program which would identify the patients in the Cherokee Hospital and other health

facilities who required continues, or on-going treatment. The CHR staff would accept the responsibility for seeing that such patients returned for necessary treatment.

5. Assisting Indian people in gaining admittance to health facilities and obtaining necessary health services.
6. Educate and promote enthusiasm for better social, mental and environmental attitudes.
7. Act as a liaison between the Indian Health Service personnel and the Indian communities and individuals. When advisable, the CHR staff will provide essential individuals with specific IHS information concerning treatment, referrals and enviromental health procedures.

The 1969 statement contains an additional category in which each of these seven major areas of service is broken down into specific activities. It is interesing to note that all activites and all major areas of service can be defined as education, information and referral functions with the exception of #5 "Assisting Indian people in gaining admittance to health facilities and obtaining necessary health services." Specifically, #5 is the only area of service which is sub-divided into activities involving the provision of transportation. The remaining areas of service involved transportation only in that the CHR staff must travel in order to provide a service (education, information, assistance, etc.). In #5, the provision of transportation is the service provided.

In evaluating the Community Health Representatives Program since 1969, it is not surprising that the provision of transportation has emerged as a major CHR service. The Qualla Indian Boundary is sparsely populated and the Cherokee communities are isolated and widely separated. The absence of adequate transportation services significantly hinders the social, economic and educational development of the Indian people. Individuals without access to effectively utilize any of the health resources and services available (medical treatment, clinics, commodity foods, welfare services, nutritional services, etc.).

C. Elemination and prevention of enviromental health hazards and problems.

1. Eliminate unsanitary and unsightly debris in and around homes by conducting educational and demonstrational activities.
2. Assist Tribal members in obtaining more adequate and suitable housing.
3. Plan and conduct a health education program oriented toward the elimination of general and specific examples of health hazards and problems.

D. Helping people get to health facilities and services.

1. Provide direct transportation and health instructions; assist in arranging transportation to hospital and clinic.
2. Provide transportation for patient's immediate family, when advisable (parents of a sick child, spouse of elderly patient, etc.)
3. Provide, or arrange for the provision of transportation for the obtaining of welfare commodities.

E. Petition Federal, State and local agencies for additional funding for health services and facilities.

1. Identify all potential Federal grant sources and complete necessary applications.
2. Utilize PHS and ICAP in procuring additional training.
3. Obtain more welfare aid for qualified applicants.
4. Assist students in acquiring scholarships, loans and assistantships.
5. Research, identify and contact all potential sources of state and county aid.
6. Help Tribal members identify all Social Security and veteran benefits where applicable.

F. Conduct a series of educational and/or informative activities designed to encourage community support for social development, educational enrichment, enviromental sanitation and personal growth.

1. Encourage Tribal members to have wills and legal documents completed, thereby preventing unnecessary dissention.
2. Stimulate a sense of unity and cooperation by encouraging people to join together in order to cope with illness, death and critical need.
3. Promote participation and involvement in religious and social activities.
4. Provide education in the fields of mental health and social relationship.

In addition to this comprehensive statement concerning goals, objectives and specific activities, this revised and expanded document contained a specific procedure for evaluating and improving the CHR Program. This process contained the following activities: (1) the CHR Program would identify specific areas in which the staff needed additional training and obtain the necessary instruction; (2) CHR Program priorities would be determined by the CHR Director, staff and the Principal Chief of the Eastern Band; (3) the CHR staff would maintain records of all Program activities, and periodically submit reports to the Council House; (4) the CHR staff would solicit evaluations, criticisms and recommendations from all agencies, services and persons involved in the operation of the CHR Program. Where possible, the Director and staff will utilize such evaluations in improving the efficiency and resources of the Program.

III. Evaluation: The Revised 1969 statement of purposes and services.

It should be expecially noted that the revised 1969 statement of purposes and services for the Cherokee CHR Program remained unchanged until 1975. During this period, the CHR staff had adequate opportunity to evaluate their effectiveness, capabilities and resources in all of the designated areas. Following is an evaluation of each activity in six (6) major areas of service.

A. Maintenance of Tribal and individual sanitary facilities.	EXCELLENT	FAIR	POOR
1. Help other resource agencies in determining enviromental deficiencies.		X	
2. Acquisition of equipment which enables the Tribe to complete necessary cleaning, renovation and cleaning of septic tanks, drain fields, etc.		X	
3. Provide maintenance and repair for springheads, indoor plumbing and water and sewer lines.	X		

	EXCELLENT	FAIR	POOR
4. When advisable, contact other agencies and inform them of the unclean, crowded and dilapidated condition of homes; request their assistance in alleviating these health hazards.	X		
B. Health Instruction to families and communities.			
1. Interpret and explain instructions, demonstrations and educational materials which are given to our people by hospital and clinic employees and other health-related agencies, services and organizations.		X	
2. In instances where complex language and technical terminology is used (pahphlets, booklets, and written instructions) to explain health services and sanitation facilities, the CHR staff will supply the same assistance as designated in #1.		X	
3. Interpret patient needs to hospital and clinc employees; assist in establishing and maintaining positive communications between doctors and patients.	X		
4. Relay any and all information which will improve communications and understanding between the Cherokee people and the Public Health Service.			X
C. Elimination and prevention of enviromental health hazards and problems.			
1. Eliminate unsanitary and unsightly debris in and around homes by conducting educational and demonstrational activities.			X
2. Assist Tribal members in obtaining more adequate and suitable housing.	X		

	EXCELLENT	FAIR	POOR
3. Plan and conduct a health education program oriented toward the elimination of general and specific examples of health hazards and problems.			X
D. Helping people to get to health facilities and services.			
1. Provide direct transportation and health instruction; assist in arranging transportation to hospital and clinic.	X		
2. Provide transportation for patient's immediate family when advisable (parents of sick child, spouse of elderly patients, etc.)	X		
3. Provide, or arrange for the provision of transportation for the obtaining of welfare commodities.	X		
E. Petition Federal, State and local agencies for additional funding for health services and facilities.			
1. Identify all potential Federal grant sources and complete necessary applications.			X
2. Utilize PHS and ICAP in procuring additional training.	X		
3. Obtain more welfare aid for qualified applicants.	X		
4. Assist students in acquiring scholarships, loans and assistantships.			X
5. Research, identify and contact all potential sources of State and county aid.		X	
6. Help Tribal members identify all Social Security and veteran benefits where applicable.	X		

	EXCELLENT	FAIR	POOR
F. Conduct a series of education and/or informative activities designed to encourage community support for social development, educational enrichment, enviromental sanitation and personal growth.			
1. Encourage Tribal members to have wills and legal documents completed, thereby preventing unnecessary dissention.	X		
2. Stimulate a sense of unity and coorporation by encouraging people to join together in order to cope with illness, death and critical need.	X		
3. Promote participation and involvement in religious and social activities.	X		
4. Provide education in the fields of mental health and social relationship.			X

IV. Justification for preceding evaluation.

The preceding evaluation can best be explained in relation to the following criteria. In all areas in which the performance standard of an activity has been designated as "Excellent," the CHR Program judges its effectiveness, capabilities and resources to be well integrated. For example, out of twenty-four activities listed under six areas of service, thirteen have been given a performance evaluation of excellent. For example. A-3 and A-4 are judged to be excellent due to the effective working relationship between the CHR Program, the Office of Enviromental Health, the Bureau of Indian Affairs and the ONAP Home Improvement Program. The rating of "Excellent" for B-3 is directly related to the beneficial relationship which exists between the CHR staff and the medical staff at the Cherokee Hospital. C-2 is a product of the excellent coordination and referral relationship between the CHR Program and Tribal supportive agencies (Qualla Housing Authority, the BIA and the OEH office). D-1, D-2, and D-3 are priority activities for the CHR Program and represent our most efficient of the Cherokee CHR staff, beneficial and relevant to our needs. E-3 and E-6 are indirectly related to D-1, D-2 and D-3 (transportation); in the process of providing transportation concerning Welfare and Social Security. This is equally true of F-1, and F-3.

Since the Cherokee staff perceives this evaluation report as a basic for improving the effectiveness, capabilities and resources of the present program, all activities evaluated as "Fair" and "Poor" will be discussed in detail.

A. Activities evaluated as "FAIR"

Essentially, the evaluation of "FAIR" indicates that the designated program activity is performed adequately, but is subject to certain limitations (resources, personnel and/or coordination). While such activities represent a vital part of the Cherokee CHR Program, the staff feels that steps should be taken to improve and expand them.

1. "Help other resource agencies in determining enviromental deficiencies." (A-1): The Cherokee CHR Program has an excellent working relationship with several agencies that are concerned with enviromental deficiencies. This is especially true of the Office of Enviromental Health, the Qualla Housing Authority and the Tribal government. However, there is a lack of comprehensive coordination in the performance of this activity. The CHR staff feels that this particular activity could be more efficiently performed if all relevant resources were mobilized in a concerted effort. This activity is directly related to the maintenance of Tribal and individual sanitary facilities. The CHR staff readily assists other resource agencies in the maintenance of sanitary facilities; however, we feel that this activity could be performed with greater efficiency if we were able to conduct specific health education activities on an on-going basis. At present, we do not have (1) a qualified CHR staff member who can devote the majority of his or her time to this aspect of health education; nor do we have (2) an effective coordination process which would enable us to provide the necessary health education through a related health agency.

2. "Interpret and ecplain instructions, demonstrations and educational materials which are given to our Indian people by hospital and clinic employees, and other health-related agencies, services and organizations." (B-1): This is a service which the CHR staff performs daily, and we consider it to be one of our most significant contributions to the health and well-being of our people. However, we are of the opinion that this activity is severely limited. The CHR staff explains and demonstrates such material at the request of hospital personnel and Indian patients. The CHR staff performs this activity for patients who come into direct contact with the CHR Program. Our present workload does not enable us to visit homes for the sole purpose of giving instructions or performing demonstrations. Again, we are of the opinion that the CHR Program should have (1) a staff member who devotes the majority of his or her time to the performance of health education; or (2) effective access to a resource agency that can provide a variety of health education activities in the communities and homes of our Indian people.

3. "In instance where complex language and technical terminology is used (pamphlets, booklets, and written instructions) to explain health services and sanitation facilities, the CHR staff will supply the same assistance as designated in B-1." (B-2): In essence, this activity does not differ from the previous activity relating to health education. Again, it should be noted that the CHR staff performs this activity on a daily basis, but we are confident that this form of health education should be the responsibility of (1) qualified CHR staff member, or (2) a resource agency that coordinates health education activities with the CHR office. Of course, the CHR staff will continue to perform this service as a part of our daily duties; but we are of the opinion that health education should not be limited to the Indian people who come in contact with the CHR staff.

4. "Research, identify and contact all potential sources of State and county aid." (E-5): Again, this is an activity which the CHR Program performs to the best of its ability. However, we feel that the amount of time which we are able to devote to this activity is inadequate. Although we are able to utilize a variety of state and county resource agencies, we feel that numerous agencies exist which are not being utilized.

B. Activities evaluted as "POOR".

All activities evaluated as "POOR" in the preceding evaluation represent areas which are neglected due to the absence of effective coordination with other resource agencies, or deficiencies in CHR resources (equipment and facilities.)

1. "Relay any and all information which will improve communications and understanding between the Cherokee people and the Public Health Service." (B-4): We particularly wish to stress the fact that the designation of this activity as "POOR" should not be interpreted as an indication that we perform this service poorly. The CHR Program takes advantage of every possible opportunity to improve communications between the Indian people and the Public Health Service. However, in our opinion, this activity represents one of the most critical needs in Cherokee. Despite the continuing efforts of the CHR staff and the Tribal government, we feel that this activity requires a coordination of effort which does not presently exist. We are of the opinion that the current lack of communications can only be corrected through an extensive health education project which is carried into every Indian community, and if necessary, every Indian home.

2. "Eliminate unsanitary and unsightly debris in and around homes by conducting educational and demonstrational activities." (C-1): Like the preceding activity (B-4), this problem can best be eliminated by the implementation of a comprehensive out-reach health education project. At present, the CHR Program does not have the staff which would be necessary to effectively conduct such an activity. Although the CHR staff is frequently responsible for the removal of unsanitary and unsightly debris, this is an activity which is conducted after the fact. We need an effective

health education program which would stress the necessity of avoiding unsanitary conditions.

3. "Plan and conduct a health education program oriented toward the elimination of general and specific examples of health hazards and problems." (C-3): This activity represents another aspect of the same inadequacies discussed in the two preceding activities. Again, we wish to note that the designation of this activity as "POOR" does not indicate that we are performing this service poorly, but that we lack the time, staff and resources to perform it adequately. As our evaluation indicates, the Cherokee CHR Program needs a Health Education component.

4. "Identify all potential Federal grant sources and complete necessary applications." (E-1): Neither the Cherokee CHR Program or the Cherokee Health Delivery System has a qualified health planner. As a result, the planning and writing of health proposals is a neglected activity. At present, the CHR Program utilizes Tribal planners from programs outside of the health delivery system. This process is inadequate because: (1) the planners do not have a knowledge of potential grant sources for health programs; (2) the planners are not familiar with Indian health needs; and (3) the planners are rarely invited to participate in Cherokee health planning activities. As a result, the CHR Program, as well as other Indian health programs are largely dependent on their own resources and capabilities.

5. "Assist students in acquiring scholarships, loans and assistantships." (E-4): Again, this is an activity that is neglected out of necessity. The CHR Program is familiar with a limited number of scholarships, loans and assistantships, but we feel certain that these resources represent a very small portion of those available. This activity could be performed more effectively if the CHR Program had access to a qualified health planner who, in addition to planning and writing health-related proposals devoted a portion of his time to identifying potential sources for scholarships, loans and assistantships.

6. "Provide education in the fields of mental health and social relationships." (F-4): The CHR Program does not have qualified personnel who can provide these services. In addition, we do not presently have access to a resource agency capable of providing this service. Our ability to function in this area will remain inadequate unless (1) We are provided with additional, qualified personnel, or (2) effective coordination of our present health resources enables us to provide this service through a related agency.

V. RECOMMENDATIONS:

A. Provide the CHR Program with sufficient funds, resources and personnel to implement a comprehensive health-education program. After careful consideration, we have concluded that this program could be implemented with three additional employees: one Community Health Educator and two teaching aides or assistants. This staff would assume the responsibility of completing the following:

1. Plan and implement a Community Health Education Program designed to improve communications and understanding between the Cherokee people and the Public Health Service.

2. Conduct a series of community and home-based projects for the purpose of eliminating unsanitary and unsightly debris; the elimination of general and specific health hazards and problems, and the provision of education in the fields of mental health and social relationships.

3. Develop, implement and maintain a resource file which identify all health-related State and county resource agencies and organizations.

4. Develop, implement and maintain an educational resource file for health-related scholarships, loans, and assistantships.

5. Upon request of the CHR staff, the Cherokee Hospital, the Indian communities and individual Indian patients, explain (a) specific health services, (b) instructions which contain complex technical or medical terminology.

B. Provide the Cherokee Health Delivery Program with the services of a competent health planner. If the employment of a health planner is impratical, we recommend that a Tribal Planner be utilized. However, we wish to stress the fact that effective and comprehensive health planning cannot be conducted unless the designated planner is (1) familiar with the health needs of the Cherokee Indian people and (2) involved in all health meetings and planning activities for the purpose of identifying major areas of need.

C. Establish an effective system of coordination which will enable the Cherokee CHR Program to utilize existing health resources.

PROGRAM DEVELOPMENT

1. Acquire additional funding and grants
2. Procure training from PHS and ICAP

COMMUNITY HEALTH REPRESENTATIVES PROGRAM

Health Education

1. Interpret and explain health materials.
2. Explain health services and maintenance of sanitary facilities
3. Interpret patient needs to hospital and clinic.
4. Improve communication and understanding between Indian people and IHS.
5. Conduct educational projects to eliminate unsanitary debris.
6. Eliminate health hazards and problems through education
7. Provide education in mental health and social relationships

Transportation

1. Provide direct transportation to hospital and clinic.
2. Provide transportation for the obtaining of welfare commodities.

Referral And Coordination

1. Identification and removal of environmental deficiencies.
2. Acquisition of equipment for maintenance of sanitary facilities.
3. Maintenance and repair of springheads plumbing and sewer lines.
4. Coordination of activities related to renovation of substandard housing and acquisition of better housing.
5. Obtain more welfare for qualified applicants.
6. Assist students in acquiring scholarships, loans.
7. Obtain supportive services from State and county agencies.
8. Assist Tribal members in obtaining social security and veteran benefits.
9. Assist Tribal members in acquiring legal help and writing wills.
10. Promote social unity and community involvement.

VI. Comments of recent revisions of Community Health Representatives statement of purpose and services (1975-76).

Although the CHR statement of purpose and services was revised in July, 1975, this does not significently differ from the program outlines in our evaluation (1969-75). All of the activities and services have been retained. In evaluating the performance of our program, we preferred to use the 1969-75 statement merely because the activities and services were grouped and clearly defined. However, should comparsion of these two statements prove valuable, the last revision (1973-74) may be found in Appendix A.

VII. Five year projection of future needs of Community Health Representatives Program.

Within the next five years, we anticipate a considerable degree of expansion and complexity within the CHR Program. Based on current program demands, resource inadequacies and anticipated growth, we have concluded that the Cherokee CHR Program has a justifiable need for the following:

A. Larger and more efficient facilities. Our current facilities have severe space, efficiency and adminstrative limitations. Since we foresee an expansion of staff, the acquisition of additional equipment, and an increase in the services provided by the CHR Program, adequate facilities are essential.

B. The implementation of an extensive health education program (See V: Recommendations).
This project will require the employment of a Community Health Educator and two teaching aides or assistants.

C. The establishment of an effective system of resource coordination.
We recommend the employment of a CHR Resource Coordinator.

D. The employment of a Health Planner , or the direct involvement of a Tribal Planner in our health delivery system.

APPENDIX A

COMMUNITY HEALTH REPRESENTATIVE

PROGRAM PROPOSAL

JULY 1, 1973 - June 30, 1974

COMMUNITY HEALTH REPRESENTATIVE PROGRAM

PROGRAM PROPOSAL

July 1, 1975 - June 30, 1976

Eastern Band of Cherokee Indians
P.O. Box 455
Cherokee, North Carolina 28719

I. PROGRAM OBJECTIVES

The reduction of disease and promotion of health in the community by extension of the general and environmental health services now available and those that will be available in the future by:

A. Instruction on maintenance and construction of Tribal and individual sanitary facilities.

B. Instructions on health care to families and communities.

c. Development of an information system through which other health resources are discovered and utilized along with the IHS Programs.

D. Development of a follow-up plan in order to insure continuity of care of individuals who have utilized health facilities within or out of the communities.

E. Provide for both emergency and non-emergency transportation for members of, and visitors to, the communities to required health facilities and services.

G. Liasion with I. H. S. personnel for miscellaneous Indian Health matters relating to the Indian community, including information in Public Health, problems in referrals, health screening and environmental health.

II. GENERAL METHODS OF REACHING OBJECTIVES

A. 1. Interpret and explain instructions on maintenance of sanitary facilities provided by the Public Health Service.

2. Interpret and explain the proper use of sanitary facilities.

3. Survey the community for needed construction of new sanitary facilities.

B. 1. Interpret and explain instructions, demonstrations and educational material given to our people by hospital and clinic employees as well as those obtained from any other health resource.

2. Interpret Tribal and individual needs to hospital and clinic employees in order to establish better relationships between health care provider and patients.

3. Establish a better and more workable relationship between all government health care agencies and the members of the Tribe.

C. 1. The community outreach worker will be oriented to other programs and resources that are available to the community and communicate this information to members of the community.

D. 1. Follow up on patients discharged from a health facility and observe any adverse changes in their condition and bring it to the attention of the facility staff and serve as a liasion in order to insure that the communities and individuals health care needs are brought to the attention of the health facility staff.

E. 1. Provide transportaion in cases of emergency to the appropriate health facility.

II. GENERAL METHODS OF REACHING OBJECTIVES (Cont.)

2. Provide or help arrange transportation for persons to whom public or private transportation to health facilities is not available.

3. Provide or help arrange transportation for obtaining welfare commodities.

F. 1. Stimulate individual and community cooperation of efforts in times of illness, death and need.

2. Promote more participation in religious and social activities.

G. 1. Orientation will be provided in the handling of all types of misunderstandings and miscellaneous problems in the course of contact between I. H. S. personnel and the Indian people of the community.

111. EVALUATION CRITERIA AND PROCEDURES.

1. Formal training will contiue to be given to meet the individual needs and requirements of the Community Outreach Worker.

2. Community Outreach Workers will meet with the Director or the Chairman of the Health Board or any members of the Executive Committee to determine priorities.

3. Records will be maintained of all activities and reports made to the Chairman of the Health Board or any member of the Executive Committee.

4. All personnel along with the Health Board will seek advice and criticism from any and all persons and agencies.

5. All data thus received, we will try to constructively implement into this program.

APPENDIX B

TRAINING

William Jackson Started work March 1972	Training Tuscon Arizona (3wks) First Aide Training Para. Professional Training	 Nov.74 Raleigh, N.C. April 74
Joe Conseen Started work May 1970	Basic C.H.R. Training Tuscon, Arizona	Dec. 1970
	Enviromental Health Workshop Philadelphia Mississippi	June 1971
	Problem Solving & Decision making	Dec. 1971
	Advance First Aid Cherokee, N.C.	Nov. 1972
	Speech & Hearing Cherokee, N.C.	Aug. 1974
	Para. Professional Miami, Florida	Mar. 1974
	Food Stamp Cherokee, N.C.	Aug. 1974
	Commodity Food Workshop Cherokee, N.C.	1973
Stella Bradley Started work Feb. 1969	Basic Training C.H.R. (4 weeks)	Feb. 1969
	C.H.R. Refresher Course (2 weeks)	Mar. 1972
	Mental Health & Alcholism Phase II	Oct. 1973
	Para. Professional Caring for Aging	Apr. 1973
	First Aid Training (Adv)	1972

	Alcoholism Workshops (4)	1971-1972
	Preparing Commodity Foods	1973
	Diabetic Clinics 96 clinics)	1973-1974
	Speech and Hearing	1974
Eugene Thompson Started work Feb. 3, 1969	Basic C.H.R. Training	Feb. 1969
	Firman's Training for pumps	Sept. 1969
	Standard and Advanced First Aid	Dec. 1970
	Community Development Workshop	Jan. 1971
	Management and Supervisory Concepts	Mar. 1971
	Community Communications	Feb & Mar. 1972
	Basic Management Processes Course	March 1972
	Rescue Training for Unit R-11	June 1972
	Equal Employment Opportunity	July 1972
	Standard and Advanced First Aid	Nov. 1972
	Management by Objectives Workshop	Dec. 1972
	Commodity Food 4 workshops	1973
	Ambulance Attendant E O U	Feb. 1974
	Care for the Elderly	April 1974
	Food Stamp Workshop	July 1974
	E N T Workshop	Aug. 1974
	Food Stamp Workshop	Aug. 1974

COMMUNITY HEALTH REPRESENTATIVES
TRAINING SCHEDULE

NAME	WORK SHOP	DATE & YEAR
Charlotte Taylor, Director Started work for the Tribe August 1973	Reporting System Sarasota, Fla.	August 1973
	Basic C.H.R.Training Tucson, Arizona (3 weeks)	Sept. 1973
	Mental Health & Alcoholism Salmonica, N.Y. (3 days)	April 1974
	Para. Professional Training Miami, Fla.	April 1974
	First Aid & Disaster Training Minot, North Dakota (4 days)	May 1974
	Reporting System Tucson, Arizona	Aug. 1974
	Food Stamps Window Rock, Arizona	Aug. 1974
	Rescue Training Cherokee, N.C. (12 hrs.)	Oct. 1974
	2 Other Food Stamp Work Shops	
	2 Work Shops Preparing Comm. Fds.	
	Para. Professional Training	Jan.8-10 1975
Sara Maney Started work July 1973	Basic C.H.R Training	Sept. 1973
	Mental Health & Alcoholism	Oct. 1973
	Para Professional Training Raleigh, N.C.	April 1974
	Speech and Hearing	Aug. 1974
	Food Stamps	Aug. 1974

Josiah Teesateskie Started work April 1974	Basic C.H.R. Training Tucson, Arizona (3 wks.)	April 1974
Lillian Thompson Started work Sept. 1972	Basic C.H.R. Training (4 weeks) Tuscon, Arizona	Sept. 1972
	Com. Health Practice Tuscon, Arizona	Oct. Nov. 1974
	Volunteer Income Tax Assistant Workshop	Jan. 1974
	Para. Professional Raleigh, N.C.	April 1974
	E.N.T. Workshop Cherokee, N.C.	Aug. 1974
	Food Stamp Cherokee, N.C.	Aug. 1974
	Training at Hospital Cherokee, N.C.	Sept. 1974
	First Aid Advanced	Nov. 1972
	Preparing Com. Foods 4 workshops	1973
	Reporting System	Oct. 1974
	Care for the Elderly	Jan. 8-10-1975

TRIBAL HEALTH PROGRAM
EMPLOYEES

AREA OR PROGRAM 51

DATE December 12, 1975

TRIBE	HEALTH PROGRAM FUNCTION	UNMET NEEDS	FY 76 PRIORITY	PROPOSED SOURCE OF TRAINING	COMMENTS
Eastern Band of Cherokee Indians	CHR Program	1	1	Advanced CHR Training	1 out of 10 have had advanced CHR training. Only one has had this
		2	2	Community Development Practical Health Training Advanced First Aide (up date cards)	
		4	4	Para Professional - care of elderly	
		2	2	Maternal and Child Health Community Health Practice Advanced CHR Training (Review)	
		8	8	Otitis Media Training Hearing Aide Repairs Medical Records Training General Record Keeping, daily reports Time Sheets - Proper use of Telephone	None except in Basic CHR Training